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HEALTH PROMOTION—DISEASE PREVENTION

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON FINANCE

UNITED STATES SENATE

NINETY-NINTH CONGRESS

FIRST SESSION

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HEALTH PROMOTION—DISEASE PREVENTION

FRIDAY, JUNE 14, 1985

U.S. SENATE,
SUBCOMMITTEE ON HEALTH OF THE COMMITTEE ON FINANCE,
Washington, DC.

The subcommittee met, pursuant to notice, at 9:30 a.m., in room SD-215, Dirksen Senate Office Building, the Honorable David Durenberger (chairman) presiding.

Present: Senator Durenberger.

[The press release announcing the hearing and background material on health promotion and disease prevention for the elderly and the opening statements of Senator Durenberger and Senator Mitchell follow:]

[Press Release No. 85-022, Apr. 30, 1985]

FINANCE COMMITTEE RESETS HEARING ON HEALTH PROMOTION, DISEASE PREVENTION

Senator Bob Packwood (R-Oregon), Chairman of the Senate Committee on Finance, announced today the rescheduling of a hearing by the Subcommittee on Health on health promotion and disease prevention strategies for Medicare beneficiaries.

The hearing, originally scheduled for May 10, has been reset to begin at 9:30 a.m., Friday, June 14, 1985, in Room SD-215 of the Senate Dirksen Office Building.

Senator Packwood said Senator David Durenberger (R-Minnesota), Chairman of the Subcommittee on Health, would preside at the hearing.

In announcing the new date for the hearing, Chairman Packwood said, "The Committee on Finance has a keen interest in receiving an inventory of the health promotion and disease prevention strategies available to Medicare beneficiaries."

"While Medicare and other Federal health programs make it possible for many elderly persons to receive treatment for an illness, the elderly are not receiving services that could help prevent future illness and disability," Packwood said. "It is time to begin exploring the potential of such services."

The Chairman said the Administration would testify on this issue, "inasmuch as the Department of Health and Human Services has established national objectives for disease prevention. Of course, HHS also funds a substantial amount of national research in this area."

He explained, "We would like to receive testimony from experts about health promotion and disease prevention mechanisms or strategies which can improve the health and well-being of our nation's elderly population.

"And, we also would like to hear from health care providers, employers, insurers and others who have experience with health promotion and disease prevention," Senator Packwood said. "This would include, but is not limited to, insurance premium differentials, as well as health education, nutrition, immunization, exercise and health care programs."

HEALTH PROMOTION AND DISEASE PREVENTION FOR THE ELDERLY

Background Paper

Prepared for the Use of the Members of
the Committee on Finance

June 1985

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HEALTH PROMOTION AND DISEASE PREVENTION FOR THE ELDERLY

INTRODUCTION

The elderly segment of our population--those persons age 65 and over--is the fastest growing segment of the U.S. population. In the first years of this century there were 3.1 million elderly persons in the U.S., comprising 4 percent of the total population. By the early 1940s, the number of elderly persons had tripled to 9.0 million, the proportion increasing to 6.8 percent. In 1980, the population of elderly persons had nearly tripled again to 25.5 million persons, or 11.3 percent of the total U.S. population.

Elderly persons, who represent just over 11 percent of the population, consume approximately 30 percent of all national health expenditures and 50 percent of the Federal health budget. Some experts estimate that the elderly may consume fully half of all U.S. health expenditures by the middle of the next century.

As the nation searches for ways to reduce expenditures for health care in general, and for Medicare in particular, increasing attention has been focused on the use of preventive health measures to reduce the burden of illness and disability, thereby improving the quality of life for the elderly population of the the U.S.

This document provides background information on the subject of disease prevention and health promotion for the elderly population of the United States. The report summarizes current knowledge in the area and describes recent developments in both the public and private sectors.

The report is divided into three parts. The first part describes the health status of the over-65 population, including a review of morbidity and mortality data for that group and a comparison with the under-65 population. The second part provides an overview of disease prevention and health promotion, with particular attention to their relevance to the elderly population. The third part describes coverage of disease prevention and health promotion services and activities under private sector insurance and employer-sponsored health programs.

There are two appendixes to the report. The first appendix describes the coverage of disease prevention and health promotion services under the Medicare program. The second appendix reviews recent legislative proposals and action related to disease prevention and health promotion for elderly persons.

I. MORBIDITY AND MORTALITY AMONG THE ELDERLY

The pattern of illness and disease has changed markedly over the years of this century. Prior to 1900 and during the early years of this century, the primary focus of health care was the control of infectious disease. The leading causes of premature death and disability were such diseases as smallpox, cholera, tuberculosis, diphtheria, typhoid fever, and measles. Preventive health measures at that time were concerned with the control of infectious disease through public health activities such as environmental sanitation, clean water, regulation of food, and immunization.

Over the past eighty years infectious disease has virtually disappeared from the list of leading causes of death. Only one infectious disease, influenza/pneumonia, remains in the ten leading causes of death and of years of life lost prematurely.

In the 1980s, the major causes of morbidity and mortality, particularly for the elderly, are heart disease, cancer, stroke, diabetes, and pulmonary diseases. As a result, the focus of intervention strategies for disease prevention is different. Prevention strategies for infectious diseases depend on community-wide social and environmental actions. Prevention measures for today's chief causes of mortality and morbidity are focused more on individual personal choices regarding such practices as smoking, eating, alcohol use, exercising, use of seat belts, and appropriate uses of medications.

The following table shows the leading causes of mortality by age group for persons aged 65 and over. In the United States, three out of four elderly persons die from heart disease, cancer, or stroke. Heart disease was the major cause of death among the elderly in 1950 and remains the major cause at the present time. Death rates from cancer have continued to rise since 1900, especially deaths caused by lung cancer. Although cancer death rates increase with age, cancer accounts for smaller proportions of total deaths in the older age groups. Cancer accounted for about a fourth of all deaths for those aged 65 to 74 years, a little less than a fifth of the deaths for the 75 to 84-year-old group, and about 10 percent for the very old.

Death Rates (per 100,000) from Selected Causes by Age, U.S., 1982.

		Age Groups		
Cause	65-74	75-84	85 and over	All Over 65
All Causes	2,885.2	6,329.8	15,048.3	5,048.8
Diseases of Heart	1,156.4	2,801.4	7,341.8	2,223.9
Malignant Neoplasms	824.9	1,238.7	1,598.6	1,022.4
Cerebrovascular Disease	193.5	675.1	2,000.8	505.7
Chronic Obstructive Pulmonary Disease and Allied Conditions	131.2	236.0	278.0	176.8
Pneumonia and Influenza	47.6	183.4	747.8	152.9
Atherosclerosis	20.6	102.9	563.0	95.2
Diabetes Mellitus	60.1	125.4	212.1	94.0
Accidents	50.9	103.9	255.9	85.8
Nephritis, Nephrotic Conditions, and Nephrosis	25.8	69.7	182.8	53.5
Liver Disease, Cirrhosis	40.1	31.1	17.9	35.3
Septicemia	15.8	41.1	106.9	31.8
Hypertension	10.8	29.0	83.2	23.0
Ulcer of Stomach and Duodenum	9.9	25.9	65.1	19.8
Anemias	3.6	11.7	34.1	8.9
Nutritional Deficiencies	2.2	9.6	41.6	8.1

Source: National Center for Health Statistics: Advance report, final mortality statistics, 1982. Monthly Vital Statistics Report, Vol. 33, No. 9, Supplement. DHHS Pub. No. (PHS) 85-1120. Public Health Service, Hyattsville, Md. Dec. 20, 1984.

In addition to their high risk of mortality, elderly persons are also at risk for a variety of chronic conditions and functional impairments such as arthritis, hypertensive disease, diabetes, and hearing impairments. These conditions may be precursors to fatal illnesses (e.g. hypertensive disease leading to mortality from heart disease), or may be indicative of physical deterioration associated with the aging process (e.g., hearing impairments). Such conditions are relatively rare in younger age groups, but the likelihood of a person having a chronic illness or disabling condition increases dramatically with age. Over 80 percent of persons 65 and over have at least one chronic condition, many of the elderly have multiple chronic conditions.

The following table compares the prevalence of chronic conditions in persons age 65 and over with the prevalence for persons age 45 to 64.

Prevalence of Chronic Conditions for Persons 65 and Older, 1981

Condition	Incidence per 1,000 Persons 65 and older	Incidence per 1,000 Persons 45-64
Arthritis	464.7	246.5
Hypertensive Disease	378.6	243.7
Hearing Impairments	283.8	142.9
Heart Conditions	277.0	122.7
Chronic Sinusitis	183.6	177.5
Visual Impairments	136.6	55.2
Orthopedic Impairments	128.2	117.5
Arteriosclerosis	97.0	21.3
Diabetes	83.4	56.9
Varicose Veins	83.2	50.1
Hemorrhoids	65.9	66.6
Frequent Constipation	59.2	22.4
Disease of the Urinary System	56.1	31.7
Corns and Callosities	51.9	35.8
Hay Fever	51.9	77.5
Hernia of the Abdominal Cavity	49.1	24.7

Source: U.S. Senate Special Committee on Aging and American Association of Retired Persons. Aging American: Trends and Prospects.

II. DISEASE PREVENTION AND HEALTH PROMOTION FOR THE ELDERLY

This section summarizes current knowledge on disease prevention and health promotion for the elderly. This section also reviews the evidence as to the value of disease prevention and health promotion for the elderly and discusses some of problems inherent in cost-benefit analyses of these interventions for elderly populations.

A. Summary of Disease Prevention and Health Promotion

Traditionally, preventive health care is subdivided into primary, secondary, and tertiary prevention. Primary prevention is defined as those activities undertaken to prevent the occurrence of disease or illness. Primary prevention involves the identification of risk factors for diseases or disabling conditions (characteristics of individuals indicating an increased likelihood of developing a disease), and reducing or otherwise dealing with them. Secondary prevention includes activities undertaken after a disease can be detected but before it is symptomatic. Secondary prevention includes early detection and treatment of diseases. Tertiary prevention activities are those measures undertaken to prevent the progression of symptomatic diseases, including rehabilitation after treatment to prevent long term disability.

The traditional distinctions between primary, secondary, and tertiary prevention tend to blur when considering prevention activities for the elderly. A single activity may simultaneously be secondary prevention for one condition and primary prevention for another. For example, the detection and treatment of hypertension is secondary prevention for hypertensive disease, whereas control of hypertension (tertiary prevention) is primary prevention for heart disease and strokes.

To avoid the conceptual problems associated with distinguishing among the traditional categories of prevention activities, this summary of health promotion and disease prevention activities for the elderly is subdivided into four general classes of activities:

1) interventions related to diseases and conditions of the elderly which can be addressed through traditional primary, secondary, and tertiary strategies, including diseases such as heart disease, stroke, some cancers, osteoporosis, and infectious diseases;
2) health promotion and education activities related to personal behaviors and such habits as smoking and diet, which contribute to individuals' risk of certain diseases;
3) interventions related to chronic impairments and functional disabilities of the elderly, such as vision and hearing disabilities, depression, alcoholism; and
4) interventions related to iatrogenic conditions (problems caused as a result of medical treatment) including primarily adverse drug reactions. 1/

1/ The organization and much of the content of this section is taken from a recent review of the disease prevention and health promotion literature by: Kane, R. L., R. A. Kane, and S. B. Arnold, Prevention and the elderly: risk-factors, Health Services Research, v. 19, No. 6, Part II, February, 1985, pp. 946-1006.

1. Diseases Amenable to Traditional Prevention Measures

Traditional prevention activities (e.g., risk-factor reduction, early detection and treatment, and rehabilitation to promote recovery) can be used to reduce the mortality and morbidity among the elderly due to diseases such as heart disease, strokes, cancer, osteoporosis, and infectious diseases. This section summarizes the risk-factors related to these conditions and describes the potential role of disease prevention activities for reducing the mortality and morbidity from these conditions.

a. Heart Disease

Heart disease is the leading cause of death among the elderly, accounting for more than half of all deaths in persons age 70 and above. 2/ The risk of cardiovascular disease increases with age. While males have a higher risk of heart disease than females, this difference tends to disappear among the elderly. Biological risk factors related to heart disease have been well documented by long-term studies, such as the Framingham study 3/. These risk factors include such underlying conditions as hypertension (elevated blood pressure), hypercholesterolemia (high cholesterol levels in the blood), and diabetes. Behavioral risk factors for heart disease include smoking, a sedentary life-style, poor dietary habits (obesity and diets high in saturated fats), and stress. Some of the behavioral risk factors are related to the biological risk factors.

2/ Kane et al., Prevention and the elderly, p. 949.

3/ Kannel, W. B., and T. Gordon, Cardiovascular risk factors in the aged: the Framingham study, in S. G. Haynes and M. Feinlieb (eds.), Second Conference in the Epidemiology of Aging, DHEW Pub. No. (NIH) 80-969, Bethesda, Md., 1980.

For example, smoking, a stressful lifestyle, and lack of exercise are all related to high blood pressure, itself a biological risk factor for heart disease.

Prevention of heart disease involves the reduction of individuals' risk factors, including: smoking cessation; modifications in diet both to reduce blood pressure (reduction of salt intake) and blood cholesterol levels (reductions in intake of saturated fats); changes in life style (exercise and stress reduction programs); and treatment and control of hypertension. 4/ There is some evidence that on a national basis, efforts to reduce these risk factors have been somewhat successful and have resulted in reductions in mortality due to heart disease over the past 20 years. 5/

b. Stroke

Cerebrovascular disease (stroke) has many of the same risk factors as heart disease. The biological risk factors associated with strokes are: high blood pressure, high levels of serum cholesterol, and diabetes. Behavioral risk factors include: smoking, lack of exercise, and poor diet (high in salts and saturated fats). 6/ There is some evidence that strokes may be due in part to irreversible damage occurring over a long period of time. For example, persons with a history of control over their diabetes are at a lower risk for stroke than persons who have not been able to control their diabetes over an

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4/ Kane et al., Prevention and the Elderly, pp. 954-959.

5/ U.S. Department of Health and Human Services, Public Health Service, Health and Prevention Profile, 1983, pp. 19-31.

6/ Kane et al., Prevention and the Elderly, p. 959.

extended period of time. 7/ Strokes are the third leading cause of death among the elderly. 8/

Prevention of strokes is similar to prevention of heart disease, including smoking cessation, dietary modification, and blood pressure control. In addition, there is some evidence that certain medications (anticoagulants, aspirin, and vasodilators) are beneficial in preventing subsequent strokes. 9/

Functional disabilities following an acute stroke are a problem for stroke patients. Rehabilitation to recover functional skills has become an accepted part of medical treatment for many stroke patients. However, while evaluations of rehabilitation programs show some recovery of so-called "activity of daily living" skills (e.g., bathing, eating and dressing), it is not clear whether rehabilitation reduces patients' need for institutionalization. 10/

c. Cancer

Cancer is the second leading cause of death among the elderly. The most common cancers among the elderly are lung, breast (women), prostate (men), colorectal, and pancreas. 11/ Risk factors for cancer include smoking (lung cancer), diets low in fiber (colorectal cancer), excessive exposure to sunshine (skin cancer), and exposure to environmental hazards such as air pollution. While there is no known method of preventing many cancers, early detection and treatment can sometimes eradicate the disease, or at least prolong the

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7/ Ibid., p. 960.

8/ U.S. Department of Health and Human Services, Public Health Service, Health and Prevention Profile, 1983, p. 187.

9/ Ibid., p. 960.

10/ Ibid., p. 961.

11/ Ibid., p. 963.

patient's life. Thus, unlike many stroke and heart disease prevention programs which are focused on primary prevention activities (risk-reduction), cancer prevention also includes an emphasis on secondary prevention (early detection and treatment).

Breast cancer can be detected in its early stages, and early detection improves the patient's prognosis. The 5-year survival rates for elderly women with "localized" breast cancer treated by radical mastectomy is 85 percent. The 5-year survival of elderly women with "regional" breast cancer is only 53 percent. 12/ A recent study suggests that for women who seek medical care for breast cancer while the disease is in its early stages, localized excision of the cancer may be a viable option to the traditional radical mastectomy. 13/ This finding may encourage women to seek early treatment to avoid the need for a radical mastectomy.

Breast cancer can be detected in a variety of ways, including physical examination, thermography, and mammography. Also, women practicing breast self-examination have been able to detect breast cancer in its early stages. The American Cancer Society (ACS) recommends that all women over age 20 practice breast self-examination and that women over age 50 have a breast physical examination and a mammography for breast tumors every year. 14/

Cancer of the cervix can be detected using the Papanicolaou (Pap) cytologic smear test. This test has been in wide use since the 1950s. However,

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12/ Ibid., p. 965.

13/ Fisher, B., et al., Five-year results of a randomized clinical trial comparing total mastectomy and segmental mastectomy with or without radiation in the treatment of breast cancer, The New England Journal of Medicine, v. 312, No. 11, March 14, 1985, pp. 665-673.

14/ American Cancer Society, Guidelines for the cancer-related checkup: recommendations and rationale, American Cancer Society, Inc., New York, New York, 1980, p. 41.

data from health surveys suggests that many women discontinue regular Pap smears after menopause. 15/ The ACS recommends that, after two successive negative smears, women should have a pap smear every three years until reaching age 65. The upper age limit in this recommendation is due to a low number of cases detected in women in this age group who have previously been screened. 16/ However, it should be noted that only 59 percent of women over age 65 have ever had a Pap smear. 17/

Colorectal cancer has the highest incidence of cancer mortality for persons over age 75 (men and women combined). The guaiac test for fecal occult blood (a laboratory test for blood in the stool) is one method for screening for colorectal cancer in its early, localized stage. A digital rectal exam and a sigmoidoscopy examination can also be used to detect colon cancer. For persons over age 50, the ACS recommends an annual digital exam and guaiac test, and a sigmoidoscopic exam every three to five years. However, the ACS also notes that the value of these tests for mass screening programs have yet to be proven in controlled studies. 18/

It should be noted that despite the indications of the value of early detection for some cancers, many of the elderly are not regularly screened. One study showed that only 27 percent of persons over age 70 accepted an invitation to take the guaiac screening test for colorectal cancer. 19/ There are a wide variety of hypotheses regarding why so few avail themselves of opportunities for cancer screening, including fear of a positive result (especially

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15/ Kane et al., Prevention and the Elderly, p. 966.

16/ American Cancer Society, Guidelines for cancer-related checkup, p. 41.

17/ Kane et al., Prevention and the Elderly, p. 966.

18/ American Cancer Society, Guidelines for cancer-related checkup, p. 41.

19/ Kane et al., Prevention and the Elderly, p. 967.

in regard to breast cancers), lack of knowledge regarding treatment alternatives, false beliefs, and unpleasantness of the procedures (e.g., sigmoidoscopy).

d. Accidents

Accidents, primarily motor vehicle accidents and falls, are the eighth leading cause of death among the elderly. Deaths from motor vehicle accidents account for 24 percent of all accidental deaths among the elderly. 20/ Only 10 percent of the elderly regularly use their seat belts while driving. An increase in seat belt usage might reduce the number of elderly dying in automobile accidents. One State, New York, has recently implemented a law mandating seat belt usage by drivers and front seat passengers.

Falls, frequently resulting in fractures, are also a significant problem for the elderly. The risk of fractures increases with age, especially among women. The incidence of hip fractures in women between ages 75 and 79 is 6 per 1000, increasing to 48.6 per 1000 for women over age 90. 21/ Depending upon the population studied, the 1-year mortality following hip fractures ranges from 12 to 67 percent. Forty-one percent of hip fracture cases are discharged from the hospital into a nursing home. The potential benefits of reducing the incidence of falls and fractures includes not only reduction in the mortality and disability resulting from these accidents, but also reductions in the cost of treating these injuries and in the cost of nursing home care for those persons who are permanently disabled.

20/ National Center for Health Statistics, Advance report, final mortality statistics, 1982, pp. 21-23.

21/ Ibid., p. 967.

Some falls are caused by environmental factors, such as frayed rugs, electrical cords, and icy sidewalks. Some are due to conditions such as Parkinson's disease, seizures, alcoholism, and strokes. It has been suggested that appropriate diagnosis and treatment of these conditions, as well as correction of vision impairments, could reduce the incidence of falls among the elderly. 22/

Osteoporosis (low bone mass) increases the risk of fractures due to falls. Osteoporosis is associated with increased bone resorption and decreased bone formation primarily among post-menopausal women. While the causes of osteoporosis are not well understood, it appears to be associated with the post-menopausal decline in estrogen levels. While estrogen replacement therapy (ERT) has been shown to arrest the loss of bone mass, ERT increases the risk of endometrial cancer (cancer of the uterine lining). Other risk factors associated with osteoporosis include: a history of diabetes, a history of use of steroids, poor nutrition (a diet low in calcium), and lack of exercise. Primary prevention of this condition begins at menopause and includes increased exercise, vitamin D supplementation, and increased calcium intake. 23/

Post-fracture rehabilitation, including early weightbearing, has been shown to be an important factor in the recovery from hip fractures. However, even patients participating in intensive rehabilitation programs and living at home generally require some home care services.

e. Infectious Diseases

Most infectious disease prevention programs are focused on childhood diseases (such as smallpox and diphtheria) with two notable exceptions: influenza

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22/ Kane et al., Prevention in the Elderly, p. 968.
23/ Ibid., pp. 969-970.

and pneumonia. These conditions are the fourth leading causes of death in the elderly, accounting for a mortality rate of 170 per 100,000 elderly persons. Nationally, pneumonia accounts for more than 50,000 deaths per year, more than half of which occur in people over 65 years of age. The elderly are more susceptible to infections, due in part to a decreased immune response and to the presence of other medical conditions. Institutionalized persons are also at greater risk of exposure to infectious diseases; the annual incidence of institutionally acquired pneumonia is around 100 per 1,000 elderly patients, as opposed to only 25-44 per 1,000 elderly in the community. 24/

Because pneumonia is frequently a result of influenza, some have argued that prevention efforts should be directed toward preventing influenza through the use of flu vaccinations. The Public Health Service has an explicit goal of achieving 60 percent vaccination against influenza among high-risk populations (including the elderly) by the the year 1990. Only about 20 percent of the elderly now receive flu vaccinations. 25/ Some data suggest that pneumococcal pneumonia vaccinations may be more cost effective for the elderly. However, questions have been raised regarding the effectiveness of both types of vaccines, due in part to a poorer antibody response to vaccinations in the elderly as compared to younger populations. 26/

24/ Kane et al., Prevention and the Elderly, pp. 972-973.

25/ U. S. Department of Health and Human Services, Public Health Service, Promoting health/preventing disease: Public Health Service implementation plans for attaining the objectives for the nation, Public Health Reports, Supplement, September-October, 1983, p. 47.

26/ Kane et al., Prevention and the Elderly, p. 973.

2. Health Promotion and Education

As indicated in the discussion above, susceptibility to many conditions is a function of certain risk-factors related to a person's life-style and personal habits. Although direct evidence linking the modification of some habits with improved health is lacking (with the notable exception of smoking cessation), most agree that encouraging a healthy life-style is worthwhile.

Health promotion and education programs may have a variety of objectives and be pursued in many different settings. These programs' objectives might include information dissemination, education on risk-factors, behavior modification (such as in smoking cessation classes), counseling, and social support and encouragement of behavioral change. These programs and activities can be incorporated into regular visits with medical personnel, provided through special classes and seminars (such as exercise, smoking cessation, weight loss or stress management courses), or simply provide information to the general public through the media (television and newspapers) or by direct mailings.

These interventions do not fit easily into the traditional models of medical treatment and health insurance. Also, it has been suggested that some of these "interventions" can be vehicles for the economic exploitation of elderly persons concerned about their health and well-being, such as in the marketing of food supplements.

a. Smoking

Smoking is associated with a wide range of conditions. In addition to the specific conditions discussed above (heart disease, strokes, hypertension, and lung cancer), smoking is also related to chronic bronchitis and emphysema.

While the benefits of smoking cessation are most easily documented in non-elderly populations, there is substantial benefit to be achieved at all ages. While the incidence of lung cancer does not decline until several years after stopping smoking, the risk of heart disease, chronic bronchitis, and emphysema declines relatively rapidly. 27/

b. Diet

A healthy diet for the elderly differs in several respects from a healthy diet for younger populations. This is due in part to the increased risk for certain diseases among elderly populations and to physiological changes occurring as part of the aging process.

The risk factors related to heart disease and stroke suggest that elderly persons should reduce their intake of saturated fats (i.e. sources of cholesterol) and salt. However, some older persons who consume packaged foods or take their meals at congregate meal sites, such as in the dining rooms of nursing homes or retirement villages, may have difficulty limiting their intake of these substances. 28/

The risk of osteoporosis among elderly women suggests that they may not get sufficient levels of calcium and vitamin D in their diets. However, with the exception of supplementation of these two substances, there is little evidence to suggest the value of either widespread use of general purpose vitamins or the use of large doses of vitamin supplements. 29/

27/ Ibid., pp. 973-974.
28/ Ibid., p. 974.
29/ Ibid.

c. Exercise

Exercise in moderation is generally believed to be good. In addition to the physical benefits, a program of regular activity can also enhance an older person's mental function through promotion of a general sense of well-being. Persons with a sedentary life-style are at higher risk for heart disease, hypertension, strokes and osteoporosis. Data suggest that habitual vigorous physical activity does reduce the risk of coronary heart disease. 30/

3. Chronic Impairments and Functional Disabilities

As they age, the elderly are more likely to suffer from chronic impairments. While these impairments are not life-threatening, they can affect the functional capabilities of the elderly. Also, while many of these impairments are amenable to intervention, it has been suggested that they frequently are ignored or given insufficient attention in the course of regular medical care. 31/

a. Vision and Hearing

Vision and hearing problems are common among the elderly. Nearly 60 percent of persons age 65 to 74 have either cataracts or glaucoma. In 1977, 16 percent of elderly persons reported that, at best, they could hear only shouted speech. While these problems are common, data suggest that the elderly were less likely than younger persons to have vision and hearing tests during

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30/ Siscovick, D. S., R. E. Laporte, and J. M. Newman, The disease-specific benefits and risks of physical activity and exercise, Public Health Reports, v. 100, No. 2, March-April, 1985, pp. 180-188.
of osteoporosis, fractures.

31/ Kane et al., Prevention and the Elderly, p. 976.

their regular medical checkups. 32/ Uncorrected vision and hearing problems may increase the risk of accidental falls and, particularly in the presence of osteoporosis, fractures.

b. Mental Health Needs of the Elderly

Even though there is a higher incidence of mental illness in the elderly than in younger populations, little research has been done on the mental health needs of the elderly. For many years, elderly persons with mental disorders were simply diagnosed as senile. While senility is often due to organic deterioration, evidence suggests that this diagnosis also may mask a number of diverse conditions. In some cases, these underlying conditions, such as depression, anxiety, and psychosomatic disorders, may be responsive to medical and psychotherapeutic interventions. 33/

Depression among the elderly is a common but complex problem. The symptoms of depression may be associated with other physical impairments, and thus can be difficult to identify. Also, it is difficult in elderly populations to distinguish between depression related to the normal grieving process or to stress as due to the loss of loved ones or to changes in functioning and lifestyle from conditions which may respond to counseling, chemotherapy, or social interventions. 34/ It has been suggested that people who are at high risk for depression could be identified and encouraged to participate in preventive counseling or therapy. These persons might include those who recently retired, whose spouse recently died, or who have recently been admitted to a nursing home.

32/ Ibid.

33/ Mielke, J., The elderly and the health care dilemma: is an ounce of prevention worth a pound of cure?, CRS Report, March 20, 1985, pp. 7-9.

34/ Kane et al., Prevention and the elderly, pp. 980-982.

The management of depression in the elderly has an important role in an overall program of disease prevention and health promotion. Stress and emotional factors can precipitate a physical illness or delay recovery. Also, if not carefully managed, the medications used to treat depression and other mental illnesses have potentially serious side effects (dizziness, visual disturbances, and sedation). Some of these medications have been implicated as causes of unnecessary falls and injuries among the elderly. 35/

It has been suggested that the treatment of emotional problems can reduce the utilization of medical care services. Reductions in the cost of medical care services due to the provision of mental health services is sometimes referred to as the "offset" effect. That is, savings due to decreases in medical utilization offset the costs of mental health services. A survey of studies of the offset effect showed that in twelve of thirteen studies, persons receiving mental health services used fewer physician services and had lower hospital utilization rates after initiating mental heatlh treatment. However, the reductions in medical care utilization did not fully offset the costs of the mental health services. In one study which computed the net cost of the mental health interventions, the savings from reduced medical care offset between 4 and 67 percent of the costs of the mental health care. Thus, the offset effect may not generate a net savings, but only reduce the net cost of mental health services. 36/

35/ Kane et al., Prevention and the elderly, p. 986.

36/ Jones, K. R., and T. R. Vischik, Impact of alcohol, drug abuse and mental health treatment of medical care utilizaiton, a review of the research literature, Medical Care, v. 17, No. 12, Supplement, December 1979, pp. 1-26.

c. Alcohol Abuse and Alcoholism

Surveys on alcohol use generally show an overall decline in use with age. However, among those elderly persons who do drink, many have alcohol related problems. Estimates of the number of elderly alcoholics vary from 7 to 30 percent of the population over age 60. 37/ Some experts suggests that even the higher estimates may underestimate the extent of this problem. Problem drinking among the elderly is often hidden, taking place within the confines of the home. Friends, relatives, and those providing care may fail to correctly identify the problem, mistaking its symptoms as frailty, senility, or the unsteadiness of old age.

Although alcohol abuse is serious at any age, among the elderly there are additional factors which exacerbate the seriousness of the problem. For example, when mixed with some medications, alcohol can have serious synergistic effects. Alcohol abuse can also increase the incidence of accidents and injuries.

Problem drinkers in old age are generally one of two types. The first are chronic or early-onset alcohol abusers who have abused alcohol throughout their lives. The second type are late-onset drinkers. This pattern of drinking may, be a response to situational factors such as retirement, declining income, or the loss of a spouse or friend. In such cases, alcohol may first be used for temporary relief and then evolve into a pattern of problem drinking. It has been suggested that it may be possible to prevent some of late-onset alcoholism by providing counseling and support to elderly persons to help them deal constructively with problems which may lead to alcohol abuse. 38/

37/ Kane el al., Prevention and the elderly, p. 982.
38/ Ibid., p. 983.

There are variety of treatments, programs, and modalities which can be used to help the elderly alcohol abuser including: drug therapies, behavior modification, self-help groups such as Alcoholics Anonymous, and counseling. However, it has been suggested that many of the existing resources for the treatment of alcohol problems are oriented toward persons in the workforce with the goal of a return to employment. This goal may be inappropriate for older problem drinkers.

As with mental health treatment, it has been suggested that the cost of alcoholism treatment is offset through reductions in medical care utilization. A survey of twelve studies found a median value of 40 percent of the cost of alcoholism treatment was offset by reduced medical care utilization. 39/

4. Iatrogenic Illness

Interventions related to iatrogenic illnesses are the fourth and final major category of activities of health promotion and disease prevention for the elderly. Iatrogenic illnesses are defined as illnesses or conditions arising from the provision of medical care. The most common iatrogenic illnesses among the elderly are drug reactions (side effects of overmedication and drug-to-drug interaction effects) and nosocomial infections (infections occuring during episodes of institutionalization).

39/ Jones and Vischi, Impact of alcohol, drug abuse, and mental health treatment on medical care utilizaiton, pp. 1-26.

a. Drug Reactions

Elderly persons constitute only 11 percent of the population, but consume 25 percent of the drugs in the United States. 40/ Estimates of the average number of prescription drugs being used by elderly persons range from 1.6 to 2.3 prescriptions per person. In one study of elderly persons living independently, 18 percent used between 5 and 9 different prescription medications. 41/ This high rate of multiple prescriptions increases the probability of adverse drug-to-drug interactions. Data show that the elderly experience medication side effects at a rate 1.5 to 3 times higher than that of younger persons.

The elderly frequently have multiple disorders, and may seek care from several physicians simultaneously. Elderly patients may not inform each doctor of what other doctors have prescribed. Also, doctors may overlook aspects of a patient's history. These circumstances can lead to instances of gross overmedication and serious drug interactions. 42/

The aging process includes physiological changes which alter the effects of medication, increasing the difficulty of determining the correct dosage for an older person. Additionally, most preliminary trials of medications are done on young subjects and provide few guidelines for adjusting dosages for older patients. 43/

Several strategies have been suggested for reducing the incidence of iatrogenic illnesses due to medications. These include: case management plans wherein elderly patients are encouraged to coordinate their medications through

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40/ Ibid., p. 985.

41/ Ostrom, J. R., E. R. Hammarlund, D. B. Christensen, J. B. Plein, and A. J. Kethley, Medication usage in an elderly population, Medical Care, v. 23, No. 2, February 1985, pp. 157-164.

42/ Mielke, J., The elderly and the health care dilemma: is an ounce of prevention worth a pound of cure?, CRS Report, March 20, 1985, pp. 9-12.

43/ Kane et al., Prevention in the Elderly, p. 986.

a primary care physician or family pharmacist, patient education provided at the time the medication is prescribed, and careful monitoring of drug therapy to ensure that dosages are kept to the minimum level necessary to produce the desired therapeutic effect. 44/

b. Nosocomial Infections

Nosocomial infections are defined as infections that develop during a period of institutionalization, either in a hospital or nursing home. The risk for nosocomial infections is three times higher in the elderly than in the general population, due in part to the higher rates of institutionalization for the elderly and to the lowered resistance of the elderly to such infections. Urinary tract infections (UTIs) are a particular problem among the elderly. Between 30 and 50 percent of institutionalized elderly persons have UTIs. Individuals with indwelling urinary catheters have a high risk of acquiring a UTI, and preventive stategies have tended to focus on this group. There are some data which suggest that the use of certain types of urinary catheters can reduce the incidence of UTIs. 45/

B. The Benefits of Preventive Measures for Elderly Populations

In general, the development of cost-benefit data for any prevention program is difficult, usually requiring data to be collected on large samples of people over many years. In addition, while the costs of prevention programs

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44/ Ibid., p. 988.

45/ Kane et al., Prevention and the Elderly, pp. 988-989.

can be measured or estimated, measurement of the benefits is frequently value-laden, depending upon subjective determination of the worth of many benefits such as preventing the deterioration of a functional impairment or increasing a person's life expectancy.

The problem of performing cost-benefit analyses of prevention versus cure for the elderly is even more difficult due in part to the problem of measuring the benefits. The potential benefits of prevention for the elderly are improvements in quality of life, decreased disability levels, increased life-expectancy, and reduced medical care expenditures. Excluded from this list are some of the economic measures of benefits which can be used for employed populations (such as decreased absenteeism or increased productivity) which are inappropriate for elderly populations. While changes in quality of life and levels of disability can be measured, at least on a conceptual basis, it is difficult to place a value on these benefits.

In addition, there are disagreements as to the potential impact of preventive care for the elderly in regard to changes in life-expectancy and the cost of medical care. It has been argued that there exists a theoretical upper limit to a natural life span, estimated to be around 85 years of age. 46/ Also, there are data suggesting that a large proportion of Medicare expenditures are related to care provided during the last two years of a person's life. 47/ If there is an upper limit to natural life expectancy, then one goal of preventive care would be to shorten the period of morbidity preceding death, thus reducing medical care expenditures. However, others have argued against the

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46/ Fries, J. F., Aging, natural death, and the compression of morbidity, The New England Journal of Medicine, v. 303, No. 3, July 17, 1980, pp. 130-135.

47/ Lubitz, J. and R. Prihoda, Use and cost of Medicare services in the last 2 years of life, Health Care Financing Review, v. 5, No. 3, Spring 1984, pp. 117-132.

concept of an upper limit to life expectancy. In the absence of an upper limit, preventive care may increase life expectancy without decreasing medical care expenditures as the period of morbidity and high use of medical care preceeding death would not necessarily be decreased. In this case, one outcome of increased life expectancy might be to increase medical care expenditures by lengthening the period of morbidity.

Given these problems of measuring the benefits of prevention programs for the elderly and the conceptual disagreements as to the potential outcomes of prevention on the cost of medical care, it is not surprising that little is known about the economic value of prevention for the elderly. Much of what is known about the risk factors for disease and the value of interventions is drawn from studies of younger populations wherein the benefits are easier to measure and demonstrate. Little is known about the relevance of transferring the evidence from studies of younger populations to older persons.

There have been some studies which have examined the effects of efforts to reduce risk factors for disease among elderly populations and which have suggested some positive benefits. A longitudinal study in Alameda County, California suggests that elderly persons who had healthier life-styles (e.g., no cigarette smoking, moderate exercise, moderate alcohol use) were less likely to die during the study's nine and one-half year follow-up period. 48/ There is also some evidence that the treatment of even mild cases of hypertension can reduce mortality. 49/ Finally, there is some evidence from community based studies that suggest that community-wide health promotion efforts can reduce the prevalence of risk factors and reduce mortality for certain diseases.

48/ Breslow, L. and J. E. Enstrom, Persistence of health habits and their relationship to mortality, Preventive Medicine, v. 9, 1980, pp. 469-483.

49/ Hypertension Detection and Follow-up Program Cooperative Group, The effect of treatment on mortality in "mild" hypertension, The New England Journal of Medicine, v. 307, October 14, 1982, pp. 976-980.

In summary, while there is some evidence supporting of value of health promotion and disease prevention for the elderly, many questions remain regarding the economic benefits of these efforts. A recent conference sponsored by the Foundation for Health Services Research generated a proposed research agenda which focused on the deficiencies in our current knowledge. These deficiencies including research on the appropriate design of health education programs for the elderly and on the relationship between health care services and the functional status of elderly persons. 50/ However, until additional reserarch is completed, determining the economic and social value of preventive interventions may remain an elusive goal.

C. Summary

There is a wide range of potential strategies of health promotion and disease prevention for the elderly. Prevention activities which fall within the traditional scope of preventive medical care include: control of hypertension (reduction of the risk of heart disease and stroke); screening for breast and colorectal cancers; and wider use of influenza and pneumococcal pneumonia vaccines. Health education efforts (by physicians and others) could focus on smoking behavior and the value of smoking cessation at any age (reduction in the risk of heart disease, stroke, lung cancer, emphysema, and chronic bronchitis); dietary counseling to reduce cholesterol and salt intake (risk factors of hypertension, heart disease, and strokes) and to increase calcium and vitamin D intake in women (reduction in the risk of osteoporosis); and

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50/ Defrise, G. H., A. S. Hersh, and M. A. McManus, A proposed research agenda for health promotion and disease prevention for children and the elderly, Health Services Research, v. 19, No. 6, Part II, February 1985, pp. 1033-1042.

counseling in regard to the value of regular exercise (reduction in the risk of heart disease, stroke, and osteoporosis). Finally, it appears that the medical profession could do more during the course of regular medical care to improve the functioning of elderly persons (diagnosis and treatment of depression, and vision and hearing disabilities) and to reduce the incidence of iatrogenic illness, particularly those related to drug reactions.

However, while there are many opportunities for health promotion and disease prevention activities, the economics of these efforts in the elderly remains unclear. There are few studies which demonstrate actual direct dollar savings (reductions in health care expenditures) or in indirect savings, such as through increases in productivity, decreases in disability days or increases in "well-being." Also, most research efforts have based their findings on younger populations and we know little about whether the results of these studies transfer to older populations.

III. PRIVATE SECTOR INITIATIVES IN HEALTH PROMOTION AND DISEASE PREVENTION

The purpose of this section is to describe the range and variety of private sector programs related to health promotion and disease prevention and to summarize the available evidence on the effectiveness of these programs.

A. Program Descriptions

Private sector initiatives in health promotion and disease prevention programs are primarily employer-based programs targeted on a firm's employees and their dependents. These programs fall into three general categories:

1) incentive programs to encourage employees to adopt a "healthy" life style, such as programs which reward employees who stop smoking or lose weight;

2) insurance plan initiatives such as premium discounts for non-smokers;

3) "worksite wellness" programs which include on-site screening and health education programs.

These programs are primarily available only to employees, and thus closed to participation for most of the elderly. However, they do provide examples of prevention activities which may work. Little data have been collected on these types of programs on a national basis. Therefore, the following discussion presents anecdotal data from selected programs to describe the range and scope of these activities.

1. Incentive Programs

Some employers offer financial incentives to employees who maintain a healthy life-style. For example, the Northern Life Insurance Company of Seattle, Washington offers financial incentives to its 176 home office employees who either stop smoking or, if overweight, lose weight. 51/ The company reimburses employees for half their costs (up to a maximum of $200 per year) of participating in smoking cessation programs, exercise classes, and weight loss programs through Weight Watchers. Any employee who stops smoking for one year can receive a $200 bonus. The company also pays up to $200 for weight loss, depending on the number of pounds the employee reduces. Ten months after initiating these incentive programs, and after establishing a virtual ban on smoking in the workplace, the company had reduced the percent of employees smoking from 25 to 19 percent, and 11 percent had lost 15 or more pounds.

Pioneer Hi-Bred in Des Moines, Iowa offers overweight employees and spouses $5 per pound lost until their desired weight is reached. If the desired weight is maintained for one year, the employee has a choice of gifts valued at $75. Of all overweight employees, 60 percent participated in the program, and 90 percent of program participants lost at least some weight. This company also pays employees and spouses $150 to quit smoking for one year, and an additional $75 dollars if abstinence is maintained for a second year. Fourteen percent of smoking employees stopped for at least two years. 52/

51/ Woodruff. L. L., Designing a smoke-free office, Business and Health, v. 2, No. 1, November, 1984, pp. 22-23.

52/ Kiefhaber, A. K., and W. B. Goldbeck, Worksite wellness, in Health Care Cost Management, P. D. Fox, W. B. Goldbeck and J. J. Spies (eds.), Health Administration Press, Ann Arbor, Michegan, 1984, p. 134.

The Hospital Corporation of America pays employees to participate in aerobic activities. Twenty-four cents is paid for each aerobic unit, defined as a mile of walking or running, a quarter mile of swimming, four miles of bicycling, or a quarter hour of aerobic dancing. The company paid out a total of $15,000 in incentives to 300 corporate office employees who participated in this program. 53/

Other corporations offering financial incentives include: Analysis and Computer Systems (bonuses for smoking cessation); City Federal Savings and Loan Association (pays all non-smokers $20 more per month than smokers); and Coors Industries (incentives for smoking cessation and weight loss). 54/

2. Insurance Plan Initiatives

Some health and life insurers have begun offering premium discounts to non-smokers. Blue Cross and Blue Shield of Southwestern Virginia offers premium discounts ranging from 7 to 14 percent for small employer groups (less than 50 employees) in which at least 80 percent of employees have not smoked for two years. 55/ The Blue Cross and Blue Shield plans in Minnesota and Oregon offer premium discounts to individual subscribers who do not smoke. The Minnesota plan offers larger discounts to older persons (22 percent) who do not smoke than to younger subscribers (only 7 percent). Discounts are not offered to subscribers enrolled through experience-rated group plans. 56/

53/ Ibid., p. 133.

54/ Ibid.

55/ Blue Cross and Blue Shield Association, Premium discounts introduced for non-smokers, Consumer Exchange, September, 1984.

56/ Blue Cross and Blue Shield Association, Minnesota plan offers premium discounts to non-smokers, Consumer Exchange, February, 1984.

A number of employers (Mendocino County School District, Bank of America, Mobil Oil, Blue Cross/Blue Shield of Virginia) and insurers (Blue Shield of California, Blue Cross of Oregon) offer incentives for employees who are low utilizers of health insurance benefits. These incentives are usually not linked to any particular types of "healthy behaviors" (e.g. smoking cessation or weight loss), but simply reward employees and dependents for not utilizing health care benefits. One disadvantage of these types of plans is that employees may be discouraged from seeking preventive services or needed medical care.

Some of these plans are based on the concept of employee "medical expense accounts" in which the employer annually deposits a specified sum of money ranging from $200 to $500. The employee can draw on the account to meet deductible expenses in the group insurance plan or to pay for non-covered services. At the end of each year, the remaining balance in the account is paid directly to the employee, carried forward into the subsequent year or credited to the employee for retirement. As a variation of this approach, employees of Blue Cross/Blue Shield of Virginia can earn vacation days by not using benefits in excess of specified limits. Some corporations only provide group incentives, whereby the entire employee group earns benefits (such as premium rebates) if the entire group's utilization and cost experience is less than predicted. 57/

The INSURE project, sponsored by health and life insurance companies and private foundations, is exploring the benefits of coverage for preventive

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57/ Fox, P. D., Plan design, in Health Care Cost Management, P. D. Fox, W. B. Goldbeck and J. J. Spies (eds.), Health Administration Press, Ann Arbor, Michigan, 1984, pp. 29-34.

medical exams linked with appropriate health education provided in primary care settings. This study age-specific protocols of preventive services, including recommendations for periodic physical examinations, laboratory testing, and questionnaires for risk factor assessment. The study also developed health education materials which could be used by primary care physicians. The study educated physicians in selected study sites in the use of these protocols and materials. A payment schedule for examinations was negotiated with participating physicians. The payment schedule included fifteen minutes of patient education in risk-reduction as a covered service. Preliminary data suggest that the exams and educational materials lead to increases in "healthy behaviors" by patients. Initial estimates suggest that these services cost an average of $59 per patient, ranging from a low of $32 for young patients to $135 for patients over age 75. This project is being extended to additional study sites. [58]

3. Worksite Wellness Programs

"Worksite wellness" programs are programs financed by employers, usually provided at the worksite (sometimes on company time), and which provide a variety of preventive health services, including but not limited to health screening, health education programs, medical treatment, employee assistance programs, and exercise programs. In some cases, these programs may be linked to an overall corporate strategy to contain health care costs, reduce absenteeism, and increase productivity. There is substantial variation in the content and focus of these programs among employers. The purpose of this section is to present information about the types of activities which may be included within worksite wellness programs.

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[58] Logsdon, D., M. Rosen, and S. Karson, Health insurance for preventive services, Journal of Insurance Medicine, v. 15, No. 1, January-March, 1984, pp. 2-9.

Worksite screening programs range from simple questionnaires designed to identify high-risk behaviors (e.g. smoking) to extensive checkups including physical examinations and laboratory tests. Data from these programs suggest that they are successful at identifying previously unknown conditions. When these programs are linked with health education and medical treatment (either onsite or by referral to the employee's personal physician), the data suggest that the health of employees is improved. Proponents of worksite screening programs suggest that these programs allow employers to target their preventive health expenditures for maximal effect. An important issue related to worksite screening is the confidentiality of the test results. Some fear that employers may use the results of these test in their hiring and firing decisions. 59/

Many employers provide their employees with health education information. Information dissemination and health education activites range from pamphlets, nutritional information in cafeterias, "health fairs," seminars, and workshops. Some employers may use their screening programs to target high risk groups for their health education programs.

Some employers take an active role in providing treatment for employees with certain health problems. Baltimore Gas and Electric Company screens its employees for hypertension, provides education for identified cases, performs regular followups to assure compliance with treatment regimens, and, if necessary, supplies medications. The potential value of worksite followup of identified cases is illustrated by a recent study conducted at the Ford Motor

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59/ Keifhaber and Goldbeck, Worksite Wellness, pp. 120-152.

Company which showed that hypertensive employees who received onsite care had the most success in controlling their hypertension. 60/ Many employers also support what is known as an Employee Assistance Program (EAP). Frequently an outgrowth of employer sponsored alcoholism and drug abuse programs, EAPs provide treatment and counseling for a variety of mental health related conditions, including personal problems (marital problems and stress reactions) and substance abuse. 61/

B. Evaluations of Worksite Wellness Programs

There are some reports of savings due to worksite wellness programs. New York Telephone estimated savings of $3 million in 1980 from its programs. During the first year of its "Live for Life" program, Johnson & Johnson found improvements in smoking behaviors, a decrease in the number of persons above their ideal weight, reductions in the incidence of uncontrolled hypertension, and fewer sickdays among employees participating in the program. The Control Data Corporation found that its smoking cessation course helped employees to stop smoking. Control Data also found that employees with good health habits had fewer hospital days and had lower health care costs. 62/

It is not clear how transferrable the effects of worksite wellness programs are to populations such as the elderly. While these programs may contribute to national objectives for health promotion and disease prevention, the most important lesson insofar as the elderly are concerned may be that people do adopt healthier practices in response to financial and other incentives. These programs also suggest the importance of a coordinated health promotion and disease prevention program which links risk-factor screening, health education, treatment, and follow-up.

60/ Ibid., pp. 128-129.
61/ Ibid., p. 130.
62/ Ibid., pp. 142-146.

APPENDIX A: MEDICARE COVERAGE OF PREVENTIVE HEALTH SERVICES

This section describes the coverage of preventive health services by Medicare under current law. Since its inception, Medicare has been intended primarily to cover the cost of treatment of acute care conditions in order to protect the elderly from the large and unpredictable costs of medical care. In general, Medicare coverage is limited to care that is reasonable and necessary for the treatment of an illness or injury. Medicare coverage guidelines require that preventive health services are covered only if they are furnished as an integral part of the physician's personal professional services in the course of treatment of an illness or injury.

Some of the preventive services which Medicare does not otherwise cover include physician checkups (examinations without treatment or diagnosis for a specific illness, symptom, complaint, or injury); outpatient prescription drugs (such as drugs used to treat and control hypertension); periodic breast examinations (which may include mammography); examinations for the purpose of prescribing, fitting, or changing glasses, contact lenses, or hearing aids (and the costs of providing those devices); and general health education and promotion activities. That is not to say physicians do not provide some preventive services such as hypertension screening or education in proper medication usage during the course of regular medical care. However, they cannot bill and be reimbursed separately for these services.

Some services which are not covered for screening of the Medicare population are covered for the diagnosis and treatment of persons with specific medical problems. For example, Medicare does not pay for mammograms performed on a routine basis, but will pay for this service if the patient has a history of breast cancer, symptoms for which a mammogram is indicated (such as a lump in a breast), or no symptoms but has a history and other factors which the physician considers significant enough to judge that a mammogram is appropriate. Similarly, Medicare does not cover routine eye examinations to detect problems of visual acuity such as nearsightedness, but will reimburse for physicians' services for the treatment of eye disease such as glaucoma or cataracts.

A. Immunizations

Medicare coverage excludes innoculations with two exceptions. As of July 1980, administration of the pneumococcal immunization, which protects against pneumococcal pneumonia, is a covered service under Medicare. Effective September 1984, Medicare covers the hepatitis B vaccine for Medicare beneficiaries including end-stage renal disease patients who are at high or intermediate risk of contracting hepatitis B.

Medicare does not cover the costs of other vaccinations, which are purely for prevention. For example, annual influenza immunizations, often recommended for the protection of the elderly, are not covered by Medicare.

B. Preventive Care in HMOs

The Tax Equity and Fiscal Responsibility Act of 1982 (P.L. 97-248) provided for capitation payments on a risk-contracting basis to health maintenance organizations (HMOs) and competitive medical plans (CMPs) who enroll Medicare beneficiaries. Under this provision, these plans are required to part A and part B benefits, but may also offer additional benefit additional benefits may include services not currently covered und such as outpatient medications and preventive health services. P P.L. 97-248, the Health Care Financing Administration sponsored stration projects in which HMOs were paid on a capitation basis. ence from these demonstration projects suggests that HMOs and C on a risk-contracting basis may offer some preventive health s Medicare enrollees, including vision and hearing screenings, examinations, and immunizations. 63/

63/ U.S. Department of Health and Human Services, Offic and Demonstrations, Health Maintenance Organization Risk Contr Medicare, Grants and Contracts Report, Health Care Financing HCFA Pub. No. 03184, September 1984, pp. 20-21.

APPENDIX B: RECENT LEGISLATION AND LEGISLATIVE PROPOSALS

In recent years, Congress has considered a number of proposals related to health promotion and disease prevention. The purpose of this section is to describe the variety of these proposals. Many of these measures were not directly or exclusively related to either the Medicare program or the elderly; however, all of them might affect the Medicare population to some degree. The approaches considered have included extensions of Medicare coverage, demonstration projects, and research proposals.

A. Medicare Coverage

Because of recently-passed legislation, vaccines for pneumococcal pneumonia (P.L. 96-611) and hepatitis B (P.L. 98-369) and their administration are now covered in certain cases. Legislation to provide Medicare coverage for influenza immunizations has been introduced on several occassions, but has never been enacted.

Two bills introduced in the 99th Congress by Senator Durenberger would amend Medicare's Supplementary Medical Insurance (SMI) program to encourage the use of certain preventive services and to discourage smoking by Medicare beneficiaries. S. 358 would raise the part B deductible from $75 to $100 but would permit payments made by beneficiaries for the costs of specified preventive health measures to be applied toward the part B deductible. These measures include health screening, as defined by the Secretary of Health and

Human Services; immunizations not otherwise covered by Medicare; and prescription drugs for the control and treatment of hypertension. The second bill, S. 357, would discount the monthly part B premium by $1 for nonsmokers.

B. Demonstration Programs

There have been two proposals to direct the Secretary of Health and Human Services to establish or fund particular prevention programs or demonstrations.

In the 99th Congress, Senator Durenberger introduced S. 359 which would direct the Secretary to establish preventive health services demonstration programs for Medicare beneficiaries. Under S. 359, the demonstraton programs would be located at no fewer than five geographically diverse and generally accessible sites. Each program would be conducted under the direction of a school of public health, be designed to allow alternative reimbursement methods (including payment on both a prepayment and fee-for-service basis), involve community outreach efforts, and be designed to facilitate the submission of a required report (which would include an evaluation of the short- and long-term costs and benefits of preventive health services for the Medicare beneficiaries who received such services under the program) to Congress within three years after the bill's enactment. Preventive health services to be made avaliable through these programs include health screenings, immunizations, health risk appraisals, dietary consultations, stress reduction, exercise counseling, and programs, smoking cessation, sleep regulation, mental health intervention (particularly targeted to preventing depression), prevention of intentional and unintentioned injury, instruction in self-care (including use of medications), and prevention of alcohol abuse. These preventive health services may be provided by physicians, behavioral scientists, nurses, allied health personnel, dieticians, and clinical psychologists.

The Health Promotion and Disease Prevention Amendments of 1984 (P.L. 98-551) directed the Secretary to fund academic health centers to establish centers for research and demonstration in the areas of health promotion and disease prevention. Three such centers were authorized for fiscal year 1985 and five for fiscal year 1986, but no funds have yet been appropriated for the financing of these centers.

C. Research

Disease prevention research has been a legislative priority in recent years. In the current session, a bill was introduced by Representative Waxman (H.R. 2409) to revise and extend the authorization of the National Institutes of Health (NIH). Among other provisions, the bill would increase the emphasis on NIH research relating to the prevention of disease. It would establish the position of Associate Director for Prevention within the Office of the NIH Director, the National Cancer Institute, and the National Institute of Child Health and Human Development. H.R. 2409 is similar to S. 540 which was passed by the 98th Congress but was subsequently vetoed by the President primarily for reasons unrelated to the prevention provisions of the bill.

Remarks

of

Senator Dave Durenberger

Health Subcommittee Hearing

June 14 1985

What we call this nation's health care system is in reality a sick care system. Doctors and hospitals have primarily been in the business of making people well rather than keeping them well. The major purchasers of health care, Blue Cross, the commercial insurers, and Medicare have reinforced this treatment and procedure orientation to medicine by reimbursing providers for the treatment of illness, not for the promotion of wellness.

We lack the incentives in our health care financing systems that encourage people to maintain their health and live healthy lifestyles. Anne Somers, a noted gerontologist, recently wrote in reference to Medicare:

> "The time has passed when the American Taxpayer can promise full coverage of health benefits to the victims of known self-destrutive behavior without asking for a contribuitons from them."

I wholeheartedly agree. Dr. Barney Clark literally smoked himself to death but Medicare still paid for the attempt to save his life. The more than $200,000 it cost to keep Dr. Clark alive for a few short months could have been saved, and a lot more done with it, if we would stop pumping Medicare dollars simply into sickness rather than health and develop policies which supply real incentives to change unhealthy ways.

This hearing will begin a process in the subcommittee to explore Medicare's potential for fulfilling its role as a true "health" insurance program.

In part, today will be spent creating a record for the Finance Committee on the contributions disease prevention can offer both to improving the health of Medicare beneficiaries and in saving program dollars. And, to explore how Medicare, as an answer, can be used to provide economic incentives to older and disabled Americans to healthy lifestyles or at least, as Dr. Somers suggests, contribute to the high cost of their self-inflicted illness.

The hearing will also review proposals I have made to incorporate disease prevention and health promotion in Medicare policy. I have introduced three bills to mandate and develop this policy:

- the first, S.357, would provide a nonsmoker discount on Medicare Part B premiums

- the second, S.358, wouldl provide riase the Part B deductible from $75 to $100 but allow out-of-pocket expenditures for health prevention measures -- health screens, immunizations and prescription drugs to control hypertension -- to count toward that deductible and finally

- the third, S.359, a bill directing the Secretary of Health and Human Services to do demonstrations in health promotion and disease prevention to give Congress direction concerning the usefulness of adopting specific preventive benefits.

I look forward to the guidance the witnesses today can provide on the policy and concerns imbedded in these proposals. I am confident the panels will provide guidance to the Subcommittee on what of prevention services work best in keeping people healthy and reducing health care costs; what means, economic or otherwise, would be most useful in encouraging individuals to alter poor habits, like smoking; and what are the unanswered questions about disease prevention and health promotion which the demonstration proposal and other vehicles could answer?

Many other questions will arise in our discussion today. I know it will be a good start to a process which has been long in coming. The Americans who die needlessly from smoking, high blood pressure, and numerous other habits and conditions have not had a health care system overly receptive to prevention. It is time we avail ourselves of the knowledge we have at hand to use the health care system for health as well as sickness.

I appreciate the time the witnesses have taken from their busy schedules to come here today. I want to assure each of your that your contribution to this session is critically important. The issues we discuss today may not all be on the "front burner" of society's concerns or the concerns of this Congress, but they ought to be; and this hearing will help them become more visible.

Statement of Senator George J. Mitchell
Health Subcommittee Hearing
Health Promotion and Disease Prevention
For the Elderly
June 14, 1985

Mr. President, I commend the Subcommittee on Health for its interest in the subject of Health Promotion and Disease Prevention Strategies for Medicare Beneficiaries, and for your committment to hold hearings on this important issue.

The Medicare Program does not generally cover the cost of preventive health care, as the program was designed primarily to reimburse the cost of treatment of acute care conditions in an attempt to protect the elderly from large and unpredictable costs of hospitalization and outpatient physician's charges.

In recent years, as the costs of medical care continued to soar, new and innovative ideas for health care cost containment began to emerge for all medical patients, including the elderly. Most recently, the medical community as well as private industry have begun to emphasize the value of preventive health care as a cost effective strategy for improving and maintaining the health of our citizens. Studies are beginning to show that changes in lifestyle, such as cessation of smoking or weight reduction have a direct causal relationship to the maintainence of health and the avoidance of costly treatments for disease.

While most of the available studies have been conducted with younger populations, they provide valuable information for the potential use of such strategies for Medicare beneficiaries. We can also assume that the changes in the lifestyles of those now in their youth and middle age will be continued throughout the older years. Therefore we must begin to assess how the Medicare Program may take advantage of health promotion and disease prevention strategies for current as well as future beneficiaries.

I look forward to the testimony presented by the scheduled witnesses at today's hearing. I believe that this committee can benefit from the experience of private industry in designing health promotion programs for their employees, and creating financial incentives in health care plans for those who eliminate unhealthful habits such as cigarette smoking.

I believe that the testimony presented today will provide valuable input for those of us responsible for the continued reform and improvement of the Medicare Program, and I thank the witnesses for their participation in today's hearing.

Senator DURENBERGER. The hearing will come to order.

I will start out by saying that the title of this subcommittee is a misnomer. It is not the Subcommittee on Health; it is actually the Subcommittee on Sickness.

The Medicare and Medicaid Programs have, as private health coverage has, financed the healing of the sick rather than the maintenance of the health of the beneficiaries of those programs. But "illness" has negative connotations, so we talk about the sick care system in terms of "health." It is now time to begin thinking about the health care system in terms of wellness as well as the cure of the ill. This will require reforming the financing systems which lack the incentives today to encourage people to maintain their health and live with healthy lifestyles.

Ann Sommers, a noted gerontologist, recently wrote in reference to Medicare, "The time has passed when the American taxpayer can promise full coverage of health benefits to the victims of known self-destructive behavior without asking for contributions from them." With this I wholeheartedly agree.

Famous dentist Barney Clark literally smoked himself to death, but Medicare paid for the attempt to save his life. The more than $200,000 it cost to keep Dr. Clark alive for a few short months could have been saved, and a lot more done with it, if we would stop pumping Medicare dollars simply into sickness rather than health, and if we would develop policies which supply real incentives to change unhealthy ways.

This hearing will begin a process in the subcommittee to explore Medicare's potential for fulfilling its role as a true health insurance program. In part, today will be spent creating a record for the Finance Committee on the contributions that disease prevention can offer both to improving the health of Medicare beneficiaries and in saving program dollars, and it will explore how Medicare, as an answer, can be used to provide economic incentives to older and disabled Americans, incentives to healthy lifestyles, or at least, as Dr. Sommers suggests, to contribute to the high cost of their self-inflicted illnesses.

The hearing will also review proposals I have made to incorporate disease prevention and health promotion in Medicare policy. I have introduced three bills to mandate and develop this policy. The first, S. 357, would provide a nonsmoker discount on Medicare part B premiums; the second, S. 358, would raise the part B deductible from $75 to $100, but it would allow out-of-pocket expenditures for health prevention measures—health screens, immunization, and prescription drugs to control hypertension—to count toward that deductible; and finally, the third, S. 359, a bill directing the Secretary of Health and Human Services to do demonstrations in health promotion and in disease prevention to give Congress direction concerning the usefullness of adopting specific preventive benefits.

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Many other questions will arise in our discussions today. The subcommittee, though it may have been misnamed for its past, can also earn the right to be the Health Subcommittee in the future.

The opportunities we explore today can provide applicable lessons for changes in Medicaid, for the more appropriate use of the tax subsidy of health insurance premiums or preventive health benefits, and/or some health promotion expenditures from the proceeds of a possible new Federal tax on tobacco.

I know it will be a good start to a process which has been long in coming. The Americans who die needlessly from smoking, high blood pressure, and numerous other habits and conditions have not had a health care system overly receptive to their efforts at prevention. So it is time we avail ourselves of the knowledge we have at hand to use the health care system for health as well as victims.

I appreciate the time that the witnesses have taken from their busy schedules to come here today; it is an impressive list of witnesses. I want to assure each of you that your contribution to this session is critically important. The issues that we discuss today may not be all on the front burner of society's concerns or the concerns of this Congress, but they ought to be, and this hearing should help them become more visible.

I will remind the witnesses that under our new leadership the Finance Committee limits witnesses to 5 minutes of oral testimony. That way we get more testimony from more witnesses, and that's good—except to the folks who like to hear themselves talk.

Senator Bob Dole has indicated that he would like especially to be here at this meeting but cannot be, because as chairman of the Subcommittee on Nutrition of the Agriculture Committee he is chairing a hearing on the reauthorization of the Food Stamp Program, and that is certainly a preventive benefit if I ever heard one.

So let us begin with our first witness who is Dr. Michael McGinnis, Deputy Assistant Secretary for Health, Disease Prevention and Health Promotion, Department of Health and Human Services, who is accompanied by Dr. Edward Schneider, Deputy Director of the National Institute on Aging of the Department of Health and Human Services.

Dr. McGinnis?

STATEMENT BY MICHAEL McGINNIS, M.D., DEPUTY ASSISTANT SECRETARY FOR HEALTH, DISEASE PREVENTION AND HEALTH PROMOTION, DEPARTMENT OF HEALTH AND HUMAN SERVICES, WASHINGTON, DC, ACCOMPANIED BY EDWARD SCHNEIDER, M.D., DEPUTY DIRECTOR, NATIONAL INSTITUTE ON AGING, DEPARTMENT OF HEALTH AND HUMAN SERVICES, WASHINGTON, DC

Dr. McGINNIS. Thank you very much, Mr. Chairman.

I am very pleased to be here to discuss the activities of the Department and Health and Human Services in disease prevention and health promotion, with particular emphasis on our efforts directed to older people. As you mentioned, with me here today is Dr. Schneider, the Deputy Director of NIA.

Mr. Chairman, we place a very great emphasis on prevention in DHHS; it is indeed a front-burner issue for us. I have extensive testimony that reviews the approach and activities in some detail. With your permission and in the interests of time, I would like to submit that testimony for the record.

Senator **Durenberger**. It all will be made part of the record.

Dr. **McGinnis**. Thank you.

My presentation this morning will be divided into two parts: First, a general overview of the conceptual underpinnings of our national prevention strategy; and, second, a summary of certain of our key prevention efforts which are targeted to older people.

First, the goals. If I may direct your attention to charts here to my left, your right, in the Surgeon General's report on health promotion and disease prevention—"Healthy People"—we have established five broad life-stage goals to be achieved by 1990. You can see here goals for healthy infants, healthy children, healthy adolescents and young adults, healthy adults, and healthy older adults. These goals were quantified. The goals are to reduce infant mortality by 35 percent by 1990, to reduce childhood mortality by 20 percent by 1990, to reduce adolescent mortality by 20 percent by 1990, to reduce adult mortality by 25 percent by 1990, and to reduce the average annual days of confinement for the older adult population, a lifestyle related goal, by 20 percent by 1990.

You will note that we have identified for each life stage also two of the more prominent health challenges for individuals in those respective age groups. This gives us the key to greater specificity in our strategy, to enable us to provide risk factors for these special problems, which are identified on the next chart.

[See chart.]

Dr. **McGinnis**. Here you see, as an example of the specificity which we were able to identify, risk factors for the major causes of death in this Nation. The causes of death are listed on the left hand side of that chart. On the right hand side are the major risk factors. Again, in the interest of time I won't review all of those risk factors; the important thing is that we now can identify, have identified, major risk factors for those causes of death.

I will point out just a couple of things about them: One is that several of the risk factors are cross-cutting—for example, smoking, alcohol—that is to say that by addressing one risk factor, we can impact several causes of death; and second, that many of those cross-cutting risk factors are behavioral in nature, which implies that we need to place a greater emphasis on lifestyle factors.

These risk factors that are identified can be rearrayed as strategy targets, which are identified on the next chart.

[See chart.]

Dr. **McGinnis**. Here you see 15 key strategy targets or priority areas which provide the focus for our national strategy in prevention. They fall into three general groups, including, from top down, the health-promotion or lifestyle-related issues that I just mentioned—smoking, nutrition, alcohol and drug abuse, exercise and fitness, and stress; the more traditional preventive services that we think of in clinical settings—family planning, pregnancy and infant care, high blood pressure control, immunizations, and sexually transmitted disease control—and the health protection or environmental areas, such as toxic-agent control, occupational safety and health, accidental injury control, community water supply and fluoridation, and infectious-agent control. We have set specific and measurable objectives in each of these 15 areas—again, to be achieved by 1990.

Next chart, please.

It is an effort, if you will, to apply the management-by-objectives [MBO] concept to the health arena. This chart shows, on the left-hand column, the major objective classes traditionally used in the MBO effort; in the middle column, business applications; and in the right column, health applications.

You can see that there are five kinds of objectives that are set for the health applications: Outcome objectives in health for reducing morbidity and mortality; we also have objectives related to risk factors, objectives related to the scope of services that we develop in targeting those risk factors, and objectives related to public and professional attitudes and awareness; as well as surveillance, evaluation, and research. We have set 227 objectives in all to be achieved by 1990 across those 15 areas.

The attainment of these objectives is dependent upon multiple activity at the Federal, at the State and local, and the private sectors. I am pleased to say that we are making good progress toward many of these objectives. We can get into the implementation efforts later, if you wish.

I would like to turn now to an area of special emphasis in this effort, and that is the prevention needs of our older citizens.

In many respects, the full spectrum of activities for all life stages is ultimately targeted to improving the health of people who are moving into those older age groups. This is important to bear in mind, but I would like to mention certain of our efforts which are specifically directed to older Americans and give special attention to one effort, an effort called the Healthy Older People Program, which derives from the point that I mentioned.

Would you like me to continue on?

Senator DURENBERGER. Yes.

Dr. MCGINNIS. I mentioned earlier the role of behavioral risk factors in disease, those factors for which each individual has some personal control.

The Healthy Older People initiative is an initiative undertaken within the context of a formal agreement between the Public Health Service and the Administration on Aging, and it is focused on improving the awareness and involvement of older people related to six key dimensions: nutrition, exercise, smoking, injury control, appropriate use of preventive services. There is growing evidence that elements of each of these can make an important contribution to health outcomes for older people; moreover, there is a compelling need to convey to our growing population of older people that there are some very positive steps they can take to enhance their life in later years.

The structure of the older people campaign is quite typical of our view that these efforts need to reflect cooperation at all levels and from all sectors; consequently, the campaign is a tripartite effort, involving not only the host of Federal agencies—in our own department, the Health Care Financing Administration, the Administration on Aging, the National Institute on Aging, and other Public Health Service agencies—but also State and local governments, and the private and voluntary sector.

For example, each Governor has designated a responsible locus for the effort, and much of the program activity is coming from private groups such as the National Council on Aging, the American Dental Association, the American Hospital Association, which is sponsoring a national teleconference on the effort in December targeted to health professionals, and the AARP, which has just released a series of public service announcements on the campaign's theme of "For a Better Life" as its very important contribution.

We think, Mr. Chairman, that there is substantial investment in this and other activities to yield the sorts of gain that are embodied in our overall goal of increasing the health and functional independence of older Americans, but these are gains which will come only from collaborative efforts involving participants of all ages and from all parts of our society.

I appreciate the opportunity to talk with you about this program. Dr. Schneider and I would be happy to answer any questions that you may have.

[Dr. McGinnis' written testimony and charts follow:]

Statement

by

J. Michael McGinnis, M.D.
Deputy Assistant Secretary for Health
(Disease Prevention and Health Promotion)
U.S. Department of Health and Human Services

Before the

Subcommittee on Health
Committee on Finance
United States Senate

June 14, 1985

Mr. Chairman and members of the Subcommittee: I am pleased to be here to discuss with you the activities of the Department of Health and Human Services in disease prevention and health promotion, with particular emphasis on efforts directed to older people.

I think it is fair to say that, until recently, the dominant focus of health care delivery in this country has reflected the traditions and practices of modern medical treatment. Over the years, health care professionals and the public at large have both come to equate "good health care" with sophisticated, highly technical interventions developed to cure or repair. But this happens to be a very costly approach for each of us individually, as well as for society as a whole. The time has come for us to broaden our definition of health care to include actions that prevent the occurrence of disease or disability and preserve health.

We are working to give new emphasis to this broader view of health in overall public health policy at the Federal level by significantly raising the level of interest and effort in prevention. This means preventing disease by taking prophylactic action and attending to environmental risks; screening to find diseases in early, asymptomatic stages when they are treatable in ways usually less costly in terms of dollars and human suffering; and promoting good health through attention to individual lifestyle. I do want to emphasize, however, that we have no intention of abandoning or compromising traditional curative and reparative medicine. Rather, our goal is to establish a new and more effective balance between curative and preventive medicine.

I am not going to try to describe all of the disease prevention and health promotion activities in the Department, or even in the Public Health Service. Rather, I will review briefly our efforts to develop and put in place broad national strategies in prevention.

I might note that this is an initiative in which the Public Health Service has sought to mobilize its own resources toward a set of highly worthwhile, attainable goals. We are called upon to fulfill a national leadership role by providing a model for the health establishment both at other levels of government and in the private sector.

Let me begin my review with what was a major effort by the Public Health Service to develop a national agenda in prevention. I am speaking of a volume entitled Healthy People, the Surgeon General's report on disease prevention and health promotion. The publication of this report set the stage and provided the framework for many of our activities related to prevention.

Healthy People reviewed and highlighted the principal, preventable health problems facing the American people, and identified various strategies that might be employed to address those problems. The message of that report was simply stated and unmistakably clear: the health of the American people has never been better and, furthermore, additional gains will be realized if we are able to deal successfully with specific sets of problems that characterize each life stage.

The discussion in a substantial portion of Healthy People focused on the five life stages, and the text set out a series of specific goals for improvements in the health of people at each of those stages that might be attained by 1990.

The five life stages are infants; children; adolescents and young adults; adults; and older adults. Specifically, the goals are: for infants, reducing the mortality rate by 35 percent by 1990 to fewer than 9 deaths per 1,000 live births; for children of ages 1 to 14 years reducing the mortality rate by 20 percent by 1990 to fewer than 34 per 100,000; for adolescents and young adults aged 15 to 24, a reduction by 1990 of 20 percent in the mortality rate to fewer than 93 per 100,000; and a reduction by 1990 of 25 percent in the mortality rate for adults aged 25-64 to fewer than 400 per 100,000. For our elderly population, the approach is a bit different. Here we did not define a mortality-based goal, but rather one that is based on morbidity and which seeks by 1990 to reduce by 20 percent the number of days of restricted activity. If the goal is attained, by 1990 the average number of days of restricted activity due to acute and chronic conditions for each of our senior citizens will have fallen below 30 per year.

These goals were accomplished by carefully determining and analyzing recent trends in death and disability rates, by extrapolating those trends to 1990, and by factoring in some additional measure to allow for improvements or advances in the state-of-the-art over time. In and of themselves, however, they represent only a portion—in effect, the end point—of a prevention strategy. To identify the other elements of our prevention strategy we undertook a very careful analysis of the factors contributing to both problems and solutions for people at various life stages. Careful consideration, for example, of the leading causes of death in our population called attention to a set of risk factors, and it is these risk factors that became critical elements in our strategy development. The fact that we can identify risk factors now for each of the causes of death reflects progress in the development of our science base and data collection capabilities in the last generation.

One of the first things that strikes you when you look at a list of the major risk factors for the leading causes of death and disability is that many of the factors are behavioral in nature, while others have their origins in environmental problems. By shifting our focus to specific risk factors, such as smoking and high blood pressure to name but two, rather than on disease, we begin our move toward identifying and formulating practical strategies to improve the health of the population.

The strategies which begin to emerge as a consequence of this line of inquiry include the more traditional kinds of preventive activities targeted to individuals, such as family planning, pregnancy and infant care, immunizations, sexually transmitted disease control measures, and high blood pressure control. Another category, called health protection, encompasses services generally targeted toward populations, such as toxic agent and radiation control, occupational safety and health, accident prevention and injury control, and community water supply fluoridation, and infectious disease control. A third category of prevention strategies, health promotion, involves attention to such issues as: smoking control; preventing the misuse of alcohol and drugs; improved nutrition; physical fitness and exercise; and controlling stress and violent behavior.

These 15 areas have become the focus of our efforts in the Public Health Service to develop a more concrete set of prevention strategies. In a document entitled Promoting Health/Preventing Disease: Objectives for the Nation, the Public Health Service took yet another major step forward by setting 227 specific, measurable objectives to be achieved across these areas by the year 1990. Attainment of these objectives will in the natural course of things move us forward in our pursuit of the major goals laid out in Healthy People.

The objectives in each of the 15 areas fall into one of five functional categories. They are objectives directed toward improved health status; objectives concerned with reducing recognized risk factors; objectives for increasing public and professional awareness; objectives for improved services and protection; and objectives that will lead us to improved surveillance and evaluation systems.

Having come this far, the stage was now set for developing implementation plans that would move us on our way toward the goals and objectives for 1990.

As a first step in the development of the implementation plans, the Assistant Secretary for Health designated for each of the 15 areas one PHS agency to assume responsibility for coordinating the development of such a plan in concert with an identified set of collaborating agencies.

The lead agencies were chosen for each area on the basis of their programmatic or statutory responsibility, experience, and expertise. For purposes of these implementation plans, the collaborating agencies were all components of the Federal government. The implementation plans were formulated by the agencies through an iterative process over the course of about a year and a half and were published as a supplement to Public Health Reports, the semi-monthly journal of the Public Health Service, in September 1983.

This brings me to a critical point about the nature of this undertaking. The implementation plans that I've just described are not plans designed specifically to guarantee achievement of our national objectives; rather, they define the Federal contribution and commitment--principally through the Department of Health and Human Services and the Public Health Service--to the process. Remember, the objectives are national, not Federal objectives, and they are meant to guide rather than prescribe. By making the objectives and the work of the Department widely available, we hope to stimulate others outside the Federal government to take a careful look at the health of Americans and how it might be improved.

In 1985, we are conducting a "mid-course" review of the status of the 1990 Health Objectives for the Nation. We expect to publish the results of this review in 1986 to serve as a basis for plans for the remainder of this decade.

Now, because of the special interests of this subcommittee, I would like to turn to a specific way in which the Public Health Service, in collaboration with the Administration on Aging, and the Health Care Financing Administration has begun to implement actions in support of the 1990 objectives as they apply to the elderly. The Surgeon General and the Commissioner on Aging joined forces to develop this initiative in order to draw attention to the need for health promotion for older persons and to help national, State, and local agencies and organizations create their own programs.

The long-term goals of a health promotion and disease prevention stragegy for our older people was first stated in Healthy People—and I quote: "The ...goal...must not only be to achieve further increases in longevity, but also to allow each individual to seek independent and rewarding life in old age, unlimited by many health problems that are within his or her capacity to control."

This premise is the basis for our national goal, set forth in Healthy People, to improve and enhance the health and well-being of our older citizens—by reducing the average annual number of days of restricted activity due to acute and chronic conditions by 20 percent, to fewer than 30 days per year for people age 65 and older by 1990.

Many activities are underway throughout the Department to help make this goal a reality, and special attention is currently being given to the gains through health promotion. For example, the National Institute on Aging recently announced two new programs to stimulate research and further our knowledge about factors related to health promotion and disease prevention. These new programs add to the Institute's ongoing scientific inquiry into how psychosocial processes interact with biological processes to influence health.

The NIA is calling for research and training for researchers to specify how particular behaviors and attitudes influence the health of people as they age, and how particular social conditions affect the development and potential modifications of these behaviors and attitudes.

In addition, the NIA is encouraging research on how social environments and health beliefs influence health and effective functioning in the middle and later years. Such research examines not only the health behaviors and attitudes of middle-aged and older people but also the behavior and attitudes of formal health care providers and of family and friends. Health beliefs include, for instance, medical beliefs about the nature of the aging processes. They also include behaviors believed by older people to promote health, as well as "illness behaviors"—that is how older individuals monitor their bodily functioning; how they define and interpret symptoms perceived as abnormal; whether they take or fail to take remedial action, utilize formal health care systems, and comply with prescribed regimens; and how they approach death.

The PHS is also working to identify what activities have the most potential for improving the health of people in this age group. A recent study entitled "Aging and Health Promotion: Market Research for Public Education," conducted by the Office of Disease Prevention and Health Promotion, the National Institute on Aging, and the National Cancer Institute (all components of the Public Health Service) and by the Administration on Aging helps provide some of the answers. The study's authors reviewed the literature on the health problems of older people and assessed, through qualitative research, the health concerns of older people. The study also examined the interest of older people in their health and their ability and desire to change their behavior. Focus group discussions were held with some 90 older people from different parts of the country to understand their views and to learn from their insights.

The results indicate that while older persons are very interested in maintaining and improving their health, their knowledge about specific habits and their links to chronic diseases and conditions is limited. The Public Health Service has identifed six areas, each related to a health condition prevalent in the elderly, as having the potential for change: fitness-exercise, nutrition, safe and proper use of medicine, injury prevention, preventive services, and smoking. I'd like to touch on each of these areas just briefly:

Fitness-exercise: Physical fitness improves cardiovascular function, muscular strength, endurance, and flexibility, and reduces the risks of heart attacks, broken bones, and lower back pain. Unfortunately, too few older Americans know about proper exercise and the accompanying benefits. Fifty-seven percent of those 65 and older do not exercise on a regular basis, according to national surveys. Already some programs have been developed that address the exercise needs of older Americans, even those who are confined to wheelchairs and beds. Meanwhile, NIA is vigorously pursuing research to determine the types and duration of exercise that is most beneficial for prevention of age-dependent diseases.

Nutrition: Nutrition is important in maintaining good health for people at all age levels. Recently, many links have been established between diet and disease. For example, recent research suggests that increases in calcium and vitamin D may slow down the rate of bone loss in osteoporosis and may prevent the increased frequency of fractures seen in older people. Some studies have suggested that more than 30 percent of cancers are related in some way to dietary factors. It is clear that our knowledge of the role of other nutrients, vitamins and minerals in aging and age-related diseases needs to be expanded. The NIA and the Food and Nutrition Board of the National Academy of Sciences will be exploring this vitally important area.

In the focus groups, it became evident that many people knew what not to eat, but they were unable to describe what constituted a balanced diet. Although some nutrition education programs have been created, programs with simple and well-integrated information on what a healthy diet is, rather than only on what ingredients or foods are to be avoided, are still needed. We suspect that this is true for all age groups, not just for older people.

Drugs: Proper use of drugs and alcohol is another crucial factor in the maintenance of health. Older Americans consume 30 percent of all prescription drugs and a disproportionate amount of over-the-counter medicines. Several people in the focus groups expressed concern over the interactive effects of the different drugs they were taking. They expressed a need for more information and guidance from health care providers. Efforts should be directed toward the training and education of health professionals about the special needs of the elderly.

Injuries: Another major cause of disability and death is accidents, particularly automobile accidents and falls. One of the reasons that the elderly sustain so many injuries during automobile accidents is that only 10 percent of them report regularly using their safety belts. While the exact cause of the many falls that result in or are associated with hip fractures has not been established, falls are attributable in part to unsafe living environments and poor physical condition.

While older people clearly need to increase their use of seat belts, many older people are aware of the risk of falling and have taken steps to make their home environments safe. Community programs should be created to provide assistance in making environmental changes in homes and nursing facilities and to provide additional information, especially to those persons who may not be aware of their high risk for accidents.

Preventive Services. Preventive health services fall into two broad categories: (1) the dissemination of information about behavioral and lifestyle choices that have been shown to influence the incidence and prevalence of specific disease conditions, with the intent of influencing these behaviors and (2) the use of specific medical interventions, such as screening procedures and immunizations, to detect disease conditions in their asymptomatic stage or prevent their occurrence altogether. The benefits of these services are not limited to children or young adults. Every age group has a need for and should receive basic preventive health measures as part of their routine health care services.

A substantial proportion of the morbidity and mortality from vaccine preventable disease now occurs in adults and the elderly. Older adults enter special high risk groups with increasing age or with onset of chronic illness and require immunizations not routinely provided to children and young adults. Immunization against influenza and pneumonccocal disease offer the potential of greatly reducing the burden of these diseases in the elderly.

To further our knowledge about the use of preventive health services, the Department convened a 21-member task force in 1984, known as the U.S. Preventive Services Task Force, to review the scientific basis of over 100 clinical preventive interventions and

> to develop a set of age- and sex-specific recommendations concerning their use in clinical settings.
>
> Smoking. The deleterious effects of cigarette smoking on human health are widely documented. Smoking is associated with a variety of disease conditions, most notably heart and blood vessel diseases, chronic obstructive lung diseases, and various cancers. We now know the decision to smoke carries with it serious implications for a person's use of health services, medical expenditures, and life expectancy, but that the decision to quit smoking, no matter how long the person has smoked or what their age, can significantly reduce that individual's risk for morbidity and mortality. We have a growing body of evidence that even if a person quits smoking at age 50, their risk for diseases such as cancer decreases. The message is clear—all people, including our older citizens, should be advised to stop smoking if they do, and never to start the habit at any age.

Another central purpose of the market research on the health problems of older people was to determine whether older people are a suitable audience for health promotion activities. The focus groups revealed that older persons are very conscious of their health and that they try to figure out ways to stay healthy. Other studies also indicated that, when educated about health habits, older persons had higher levels of compliance and behavior change than those in other age groups. This leads us to the conclusion that older people constitute an interested and enthusiastic audience for health information.

At this point I'd like to describe some of the special features of our health promotion intiative.

- At the Secretary's request, the governors of almost every State have named agencies to coordinate health promotion activities for older people. Based in the State health department or State office on aging, these lead agencies are working to organize statewide health promotion programs in aging on a continuing basis. As of this date, 31 States have statewide health promotion campaigns underway on behalf of older persons.

- To provide support and technical assistance to State and local agencies, the AoA, with assistance from the AoA-PHS Health Promotion Steering Committee, developed a publication distribution plan consisting of more than 30 publications in the four priority areas of injury control, proper drug use, better nutriton, and improved physical fitness. One document, "A Healthy Old Age: A Source Book for Health Promotion With Older Adults," has already been printed for this initiative. AoA has sent more than 15,000 copies of this publication to State agencies on aging, community and migrant health centers, Indian tribes, service units of the Indian Health Service, and OASIS projects (mini-senior centers located in department stores). Other materials will be distributed as they become available.

- AoA is in the process of developing two new documents as part of this initiative. The first is a process guide for use by State and local health aging units to set up health coalitions and programs, and the second is an annotated bibliography on health promotion.

- AoA serves more than 9 million older persons each year through its various programs, many of which include health promotion activities. AoA-sponsored nutrition programs also provide meals to more than 3.5 million older persons each year. In addition, AoA supports numerous health-related projects through its discretionary funding of education and training programs in gerontology as well as through its research and demonstration grants.

- Within the PHS, the Food and Drug Administration (FDA) has created a seminar series in conjunction with several other agencies, addressing the issue of geriatrics and drugs. Also, a series of articles on the elderly and nutrition is now appearing in the magazine, The FDA Consumer.

  A coordinated effort is also underway to investigate many of the issues related to geriatric drug use, including the development of guidelines for geriatric drug testing. In addition, FDA is involved in major consumer education initiatives on sodium labeling, patient education on prescription medications, and health fraud. The agency conducted two consumer outreach programs designed to teach economically disadvantaged black elderly how to reduce sodium in their diets and to make the rural elderly more aware of health promotion messages on nutrition, medications, and medical devices. With regard to health fraud, a special unit has been established to address this specific issue in the drug area. FDA's consumer affairs officers, located throughout the country, continue to work with State and local organizations to bring priority health education messages to the elderly.

o Injury prevention for older Americans has received attention from the Centers for Disease Control (CDC). CDC recently produced "Prevention of Injury to Older Adults," a selected bibliography providing an overview of the magnitude of injuries among older adults and the types of health education methods and programs being conducted to reduce them. CDC has also initiated a project with the Dade Country, Florida, Department of Public Health to assist the country in designing and conducting an epidemiologic population-based study of the elderly to determine the causative factors of nonwork-related injuries. This project will develop, implement, and evaluate a model prevention program designed to reduce the incidence of injuries and their associated costs.

o As part of the initiative, the Department has awarded in FY 1984 more than $1 million in grants for health education projects aimed at the elderly to 51 community and migrant health centers in 29 States.

- In 1983, the Secretary assembled a special task force to evaluate the current medical knowledge of Alzheimer's disease, an incurable condition that affects approximately 2 million older Americans. In September 1984, a report on "current knowledge, promising directions, and recommendations" was issued. In conjunction with this departmental effort, AoA has launched a major campaign for the development of support groups for families of older persons with Alzheimer's disease. The goal of this effort is to inform the aging network about the nature of Alzheimer's disease and to encourage the development of support groups to help families cope with the problems created by the disease. AoA has developed a four-volume technical assistance "Handbook on Alzheimer's Disease" to provide background materials and to assist States and local governments, health professionals, and families in grappling with this problem.

- As a centerpiece of this initiative, we will be providing materials and technical assistance to States to assist them in conducting public education programs on health promotion for older adults. Under the direction of the Public Health Service, a variety of radio, television, and print materials will be produced for local distribution, including public service announcements and broadcast materials for talk shows.

Print materials will provide indepth information on specific health topics and alert the public to the campaign. Regional workshops will be held in the Fall to familiarize participants with public education materials and to give assistance on how to work with the media and provide health promotion services for older people.

A health promotion initiative of this magnitude is a major undertaking and one which the Federal Government cannot conduct alone. I am very pleased to say that we have already been joined by a number of organizations that share our interest in the health needs of older people. Three such groups are the American Association of Retired Persons, the American Hospital Association, and the National Council on Aging.

- The American Association of Retired Persons (AARP) has produced five public service announcements in collaboration with HHS and distributed them, along with HHS-developed materials, to State contacts. AARP is working with the Office of Disease Prevention and Health Promotion on all aspects of materials development for the public education program.

- The American Hospital Association will sponsor with HHS a national teleconference for health care providers in December of this year to increase professional attention to the needs of older Americans.

- The National Council on Aging and its many member organizations have already begun to urge their members to participate actively in these programs.

Our intiative is also complemented by activities of the Health Care Financing Administration (HCFA). The Medicare program administered by HCFA has several initiatives underway that are designed to promote better health and prevent illness among the elderly.

The first of three that I'll mention concerns HMOs. HCFA is in the process of implementing a law that fosters greater participation of health maintenance organizations (HMOs) and competitive medical plans (CMPs) in the Medicare program. The structure of HMOs gives them incentives to provide comprehensive services and promote healthy lifestyles. The provision of preventive procedures and education on appropriate practices to promote good health assist HMO members in avoiding expensive hospital stays. We know that health education of patients is effective in decreasing their use of ambulatory health care services as well.

A recent demonstration conducted by HCFA found that health education provided by an HMO/CMP resulted in a significant decrease in total medical visits and in incidence of minor illness among the HMO members. Because of their preventive focus, HMOs offer great potential to the elderly as high-quality, cost-effective health care delivery systems.

Nearly 1.1 million Medicare beneficiaries now receive their health care from HMOs and CMPs. The new law will make HMOs and CMPs an even more attractive alternative by allowing them to pass on cost savings to beneficiaries in the form of increased services or reduced premiums. HCFA expects a dramatic rise in HMO enrollment by Medicare beneficiaries--by as many as 600,000 in the next 3 to 4 years, with a 50- to 100-percent increase in the number of contracts between HMOs and Medicare.

HCFA is funding several research projects involving preventive services: how the opportunity to obtain preventive services relates to individuals' decisions to join HMOs rather than participate in the traditional fee-for-service system; the effect of this type of insurance coverage on the amount of preventive care used; the amounts of preventive care used in prepaid systems versus fee-for-service settings when there are no out-of-pocket charges; the responsiveness of consumer demand to changes in the price of preventive care; and the effects of preventive services on the cost of care in the clinic setting.

Also of interest are recent changes which added to the Medicare benefit package coverage of pneumococcal and hepatitis B vaccines. These two vaccines have demonstrated their ability to prevent unnecessary illness and lost productivity.

The Department of Health and Human Services has a rich and varied program of activities to ensure the health and well-being of our older citizens. But our efforts cannot stop here. Public and private organizations have been very responsive to the initiative on the aging, and they are continuing to develop new programs that serve the needs of the elderly. Continued public-private collaboration can ensure that the impact of this initiative is not short-lived. Resources can be directed at the development of programs at the State and local levels. On a national level, we can continue to stimulate health promotion activities for older persons. All of these efforts will contribute to the maintenance and improvement of the health of the elderly, enabling them to enjoy more satisfying lives.

Health Status Goals

Goal 1. Healthy Infants (below age1)

Subgoal: To reduce the incidence of low birth weight infants
Subgoal: To reduce the incidence of birth defects

Goal 2. Healthy Children (age 1-14)

Subgoal: To enhance childhood growth and development
Subgoal: To reduce childhood accidents and injury

Goal 3. Healthy Adolescents/Young Adults (age 15-24)

Subgoal: To reduce death and disability from motor vehicle accidents
Subgoal: To reduce misuse of alcohol and drugs

Goal 4. Healthy Adults (age 25-64)

Subgoal: To reduce heart attacks and strokes
Subgoal: To reduce the incidence of cancer

Goal 5. Healthy Older Adults (age 65 and above)

Subgoal: To increase the proportion of older people who can function independently
Subgoal: To reduce premature death and disability from influenza and pneumonia

Health Strategy Targets

Health Promotion for Population Groups

- Smoking cessation
- Alcohol and drug abuse reduction
- Improved nutrition
- Exercise and fitness
- Stress control

Preventive Health Services for Individuals

- Family Planning
- Pregnancy and infant care
- Immunizations
- Sexually transmissible diseases services
- High blood pressure control

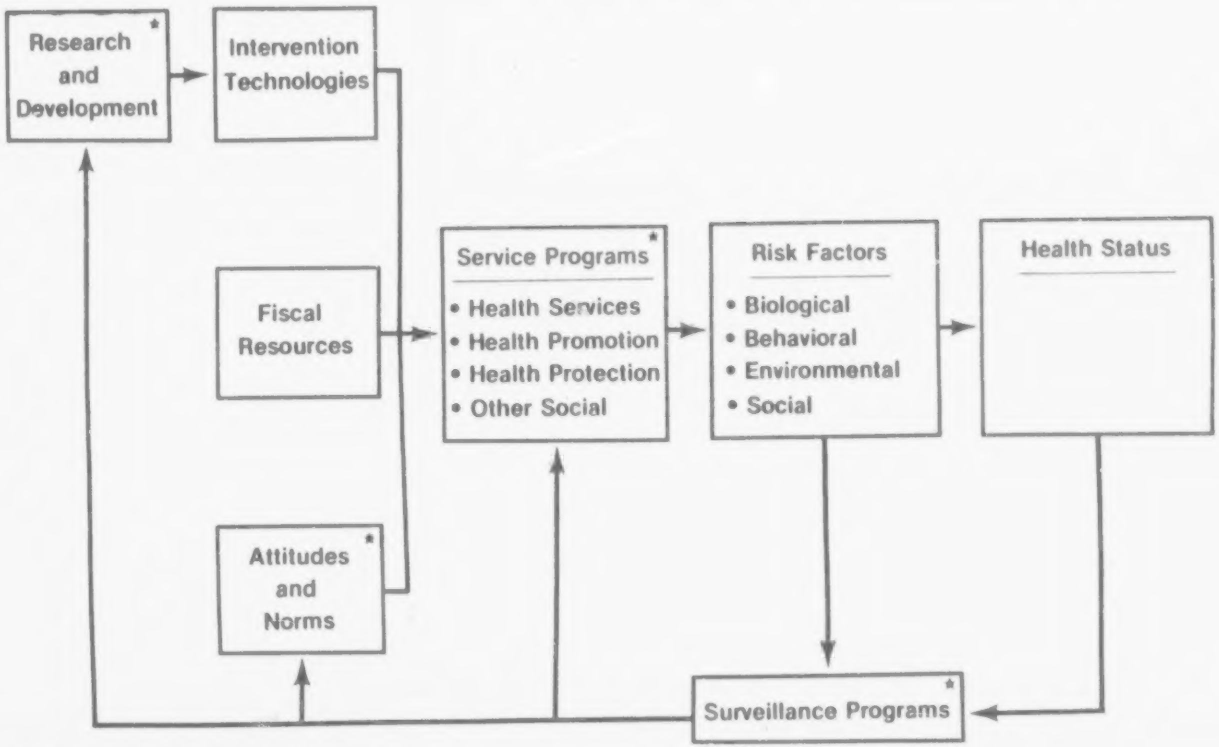
Health Protection for Population Groups

- Toxic agent control
- Occupational safety and health
- Accidental injury control
- Community water supply fluoridation
- Infectious agent control

Application of the Management by Objective Concept

Objective Classes	Business Applications	Health Applications
Outcome Objectives	Profits	Morbidity reduction
Strategy Objectives	Product type and mix	Risk factors
Productivity Objectives	Labor/capital mix	Scope of services
Marketing Objectives	Client attitudes and awareness	Public/professional attitudes and awareness
Innovation Objectives	Product improvement	Surveillance, evaluation and research

Factors Determining Health Status


Research and Development *
Intervention Technologies
Fiscal Resources
Attitudes and Norms *
Service Programs *
• Health Services
• Health Promotion
• Health Protection
• Other Social
Risk Factors
• Biological
• Behavioral
• Environmental
• Social
Health Status
Surveillance Programs *

* Focus for Management by Objectives Effort

Lead HHS Agencies for Objectives

Category	HHS Agency/Office
Preventive Services	
High Blood Pressure Control	National Institutes of Health
Family Planning	Office of Population Affairs
Pregnancy and Infant Health	Health Resources and Services Administration
Immunizations	Centers for Disease Control
Sexually Transmitted Diseases	Centers for Disease Control
Health Protection	
Toxic Agent Control	Senior Advisor for Environmental Health
Occupational Safety and Health	Centers for Disease Control
Accident Prevention and Injury Control	Centers for Disease Control
Fluoridation and Dental Health	Centers for Disease Control
Surveillance and Control of Infectious Diseases	Centers for Disease Control
Health Promotion	
Smoking and Health	Office on Smoking and Health
Misuse of Alcohol and Drugs	Alcohol, Drug Abuse, and Mental Health Administration
Nutrition	Food and Drug Administration
Physical Fitness and Exercise	President's Council on Physical Fitness and Sports
Control of Stress and Violent Behavior	Alcohol, Drug Abuse, and Mental Health Administration

Senator DURENBERGER. Let me ask you first: A recent report by CBO and CRS showed that one out of every four children is born into poverty today. In addition, one out of every six children under the age of 18 has no form of health insurance, public or private. I guess as I go around the country listening to people talk about our problems, this one, which was the first part of your chart, is the one that bothers me the most. In fact, somebody told me in the last few weeks that they felt the largest cause of death for children in America today was poverty.

What role does the Department of Disease Prevention and Health Promotion play in research and education and coordination of children's health care.

Dr. MCGINNIS. We have a very important role in that respect. As you noted, one of our major life-stage goals is reducing infant mortality by 35 percent, and one of the major 15 priority areas is pregnancy and infant health. We have set not only quantifiable targets to improving infant health and maternal health, but we have developed a series of quite elaborate implementation plans to try to target on the key problems. Those problems stem from a variety of issues; the most important contributor to infant mortality is that of low birth weight. There are a variety of complex factors that yield low-birth-weight infants, not the least of which are some of the very lifestyle-related issues that I mentioned: to issues related to smoking by mothers during pregnancy; to maternal nutrition habits; to, in addition, the involvement of mothers early in pregnancy in prenatal care programs.

Many of these efforts require educational components, an effort to reach out and inform pregnant women about the importance of their habits and about the importance of their seeking care early on.

Senator DURENBERGER. That's great. And I need to know what your specific role is. Do you just put out pamphlets that say that? I can't recall having felt your influence—not you personally, but the influence here in the last 4 or 5 years on the maternal-child health. Maybe you have been here, but I haven't felt it. What is your role?

Dr. MCGINNIS. Our role in the prevention arena is to coordinate the vast array of departmental activities in this area. They include not only the work of the Health Care Financing Administration in providing early care, appropriately, through the EPSDT Program, but also the work of our Health Resources and Services Administration with the provision of Maternal and Child Health grants for services to vulnerable populations; and in addition, our participation in national cooperative efforts with groups like the March of Dimes and a variety of other private sector organizations to reach out to the community level and provide information to pregnant women and bring them into the systems that are made available through our finance programs and through our direct service-delivery programs.

As you know, we have an extensive program to provide health services to under-served populations, both through the MCH grants and through the community health center programs.

Senator DURENBERGER. But part of your function is then to push information on people, which is certainly extremely important, and particularly on people who run programs, or financing programs. Is that correct?

Dr. McGinnis. Yes; that's correct.

Senator Durenberger. But when it comes to getting to the top, when somebody like the Secretary of HHS has to make a decision on supporting a specific legislative initiative, have you actually pushed legislative initiatives in the area of health promotion?

Dr. McGinnis. Our major focus is not on legislative initiatives, it's on making sure that our programs that are in place are working efficiently to reach their full potential. By setting specific objectives, as an example, it keeps us focused on priorities and compels us to ask why, when we are not doing as well as we had hoped. It also helps us to identify frailties in our data-collection efforts. Our job is to provide the emphasis and policy oversight for the work of each of our service-delivery programs. These are service-delivery programs, obviously.

Senator Durenberger. All right. Please—I am not asking any of these questions to be critical; I am trying to define what it is your agency does in this area. What I see here is absolutely terrific, but I have never, at least since I have been here, seen the policy budgetary types talking about any of this stuff. I suspect that they have heard it and they have seen it, probably hundreds of times; but it doesn't come out.

Is it true that the poor in America are sicker today than they were just a few years ago?

Dr. McGinnis. I think that is very difficult to know. We don't have any strong indication that that is the case. Our major indicators suggest that all Americans are indeed healthier than they were a few years ago. Our data, though, are largely aggregate in nature, and so it is difficult for us to say whether, in spite of these major changes in improvements in the health of the American population as a whole, there is a countertrend in the lower socioeconomic subset of that population.

We don't have an indication that that is in fact the case. We do have an indication that for some areas they are not making the progress as rapidly as we would like them to be making progress; but for the most part it seems that health is improving for all sectors of our society. It is a question of relative magnitude from section to section.

Senator Durenberger. What role, if any, does your agency play for the different health-financing programs—Medicare, Medicaid, maternal and child health? Do you interface with each of them? Do you require them to interface with each other? Just exactly how does that work?

Dr. McGinnis. Well, our principal role is with the Public Health Service, although we do work with the Health Care Financing Administration on issues related to, for example, the focus of one of your bills on demonstrations in health promotion and disease prevention.

We have staff that work with the Health Care Financing Administration in helping to design the nature of the demonstrations. We also work through the establishment of cross-cutting committees. For example, we have a Nutrition Policy Board that includes not just the Public Health Service but representatives from other agencies.

Senator DURENBERGER. Bill Bradley has a question he wanted me to ask you: In August 1983, HCFA solicited applications for "demonstration projects to assess the economy and efficiency of expanding Medicare coverage to include preventive services." The demonstration was to include both an experimental and a control group, with the experimental group receiving a package of preventive services offered annually and reimbursed at $100 per enrollee. Evaluation was to be made in terms of both health status and cost effectiveness.

The HCFA Office of Research and Demonstrations had earmarked $3 million for 6 years—that is, $500,000 per year—for three projects. Two years have passed, and no awards have been made. Why? When do you expect the awards to be made? If HCFA does not award the grants, we may need to pass legislation to mandate that demonstration grants be carried out in this area. Would the Department be supportive of legislation in this area?

You may not be the right person to ask these questions of, but I am sure you have some information on it.

Dr. McGINNIS. Well, I think you are right. The question will be answered by the Health Care Financing Administration. We will ask them to provide information on that directly. I can tell you that it is my understanding that a review of grant proposals has been completed, that certain of the proposals have been approved, and that approval for the waiver authority is currently under review at the Office of Management and Budget.

[The answer follows:]

DEPARTMENT OF HEALTH & HUMAN SERVICES
Office of the Secretary
Washington, D.C. 20201

JUL 16 1985

Ms. Shannon Salmon
Committee on Finance
Room SD-219 Dirksen
United States Senate
Washington, D.C. 20510

Dear Ms. Salmon:

Enclosed are responses to follow-up questions of Senator Durenberger and Senator Bradley to Dr. Michael McGinnis for the June 14 Subcommittee on Health hearing. Please call Flo Hassell of my staff at 245-2966 if you have any questions.

Sincerely yours,

Trisha Knight

Patricia Knight
Acting Deputy Assistant Secretary
for Legislation (Health)

Enclosure

1. How does the cost of cigarettes affect use? Will a higher tax constrain use?

   One study conducted in the early 1970's found that every 10 percent increase in the cost of cigarettes resulted in a one percent drop in smoking by males; no such change was found in the smoking of females. The study was repeated in 1975 and found no significant correlations between cost and prevalence of smoking. Recently, however, studies conducted by Eugene Levitt, Ph.D. and associates at the New Jersey School of Medicine and Dentistry found a reduction in cigarette consumption by minors to be correlated with increases in price. Though there is no proof of a cause-effect relationship, the National Center for Health Statistics reports that male smoking decreased 10 percent between 1980 and 1983, a period which saw an increase of about 20 percent in the cost of cigarettes due to the increased Federal excise tax and increased production costs that were passed on to distributors. Again, no such decrease in smoking was found among females.

2. If we were to spend the cigarette tax money on prevention or have the States spend that money for such purposes, what would be the activities you would fund, activities which are not funded now or may be underfunded?

The 1990 Health Objectives for the Nation serve as a useful framework for program planning. Under the Smoking Objectives, programs specifically aimed at populations among which the prevalence of smoking is remaining constant would be appropriate candidates for such support. Other objectives would also offer possible program areas, such as those under Pregnancy and Infant Health, which involve the contribution of smoking to the incidence of low birth weight infants and infant mortality and morbidity; or those under High Blood Pressure, relating to programs to prevent and control hypertension. Another approach which would cut across most of the 1990 prevention objectives would be to use funds for basic health education in the schools. This approach would have the appeal of using funds for a broader population in a primary prevention mode. Smoking could be one of many health issues addressed.

Response to Question from Senator Bradley

In August, 1983, HCFA solicited applications for "...demonstration projects to assess the economy and efficiency of expanding Medicare coverage to include preventive services." The demonstration was to include both an experimental and a control group, with the experimental group receiving a package of preventive services offered annually and reimbursed at $100 per enrollee. Evaluation was to be made in terms of both health status and cost effectiveness. The HCFA office of Research and Demonstrations had earmarked $3 million for 6 years--$500,000 per year for three projects.

Two years have passed and no awards have been made. Why? When do you expect the awards to be made?

If HCFA does not award the grants, we may need to pass legislation to mandate that demonstration grants be carried out in this area. Would the Department be supportive of legislation in this area?

HCFA published a grant solicitation in the August 12, 1983 Federal Register to demonstrate the effects of Medicare reimbursement for primary prevention in clinical screening and health education/promotion services. We received 19 applications in response to the solicitation which were reviewed by a panel of experts in January 1984. The panel assessed each application and made its recommendations to HCFA. The final selection of demonstrations was then delayed because of the need to obtain estimates of the cost/savings of the proposals. Because of other priorities, it was necessary to contract for actuarial services necessary to perform these estimates. The actuarial analysis was completed in January 1985. The final demonstration decisions are now undergoing review.

The enactment of legislation would duplicate our current authority and unnecessarily mandate the implementation of studies that we expect to have underway.

Senator **Durenberger**. One of the other things that bothers me as I travel around is the interface between Medicare and Medicaid for the elderly, what they commonly refer to as "the povertization of the elderly" in order to qualify them for State programs of one kind or another, none of which seem to be too well integrated. I see a lot of frustration on the part of people around the country who are trying to work with the poor elderly in accommodating acute care, subacute, chronic and the long-term care kinds of issues. Do you see what I will call an "inefficient" use of national and State resources in meeting the overall set of health needs for the elderly in this country?

Dr. **McGinnis**. I think, again, since that is principally a financing issue, you are asking the wrong person. The Health Care Financing Administration is in the best position to address that.

From a personal point of view, in terms of implementing our overall strategies for prevention, and the departmental contributions to those strategies—again, these are national and not just Federal strategies—I don't see inefficiencies of the magnitude that they are impinging on progress in the aggregate sense, because we, I hasten to point out, are making substantial progress across the board toward our general objectives.

While it is clear there are always inefficiencies or relative inefficiencies that we would like to see reduced, I think it is important to bear in mind the larger picture, which is that we are making substantial progress.

Senator **Durenberger**. I was reminded of the fact that HCFA declined to come to this meeting today and to respond to some of these questions, so you are stuck. And I guess the frustration is that I know, or I guess I know, in the macro-sense that people are healthier. I mean I know I quit smoking last December, so I guess I am somewhat healthier or potentially healthier than I was 1 year ago. And I assume a lot of other people have quit, too. So in a general sense I guess many of us are healthier.

But, Lord, when I go around the large cities of this country, I just see sicker people. And I don't have to look very hard; I can go to a senior center in Chinatown in San Francisco, and I can see people trying to do innovative things there for the elderly and being frustrated by this Federal program or that State program, or some other financing barrier. You can go into all of the downtowns of our large cities and find people holed up on the second floor of decrepit old hotels, and you know they are getting sicker. You know they are not eating, you know all of that, and they are showing up in emergency rooms of hospitals, costing us a lot of money.

What I am getting at is—are the poor sicker today?

Dr. **McGinnis**. Well, let me respond to that. I think it is a very critical issue. My sense is that it reflects to some extent our greater awareness of where problems lie. It is not necessarily true that people are in fact getting sicker, but we are more aware—perhaps because we are concentrating more specifically on what is possible, and concentrating more specifically on vulnerable target groups. We are more and more aware of those problems that do exist.

I don't think it means that we are in a trend for the worse. I think it means that we have a greater insight as to where we need to provide even greater focus and where our challenges continue to demand our attention.

Senator **Durenberger**. All right.

Let me ask you about one of those related issues that comes up here all the time at budget time, and that is the pneumococcal and hepatitis B-vaccines.

Have you any data to suggest that the coverage of these vaccinations has or has not been cost-effective for the elderly in this country?

Dr. **McGinnis**. The most straightforward answer is that the data are still emerging on this issue. On hepatitis, for example, we do have some data for the Medicare population that indicates that the use in hemodialysis units has yielded a decrease in incidence in hepatitis-B and therefore a decrease in the cost. So there is a very positive and encouraging indication there.

Other studies have been undertaken on younger populations and indicate some cost-effectiveness as well, but we need to look at this for a longer period. But it is hopeful. It is optimistic at this point.

On the pneumococcal immunization, we have a study from the Office of Technology Assessment which indicated that for every year of additional life which was yielded by the vaccine, an investment of approximately $6,000 was required. In relative terms—that is, in terms of comparing the required investments for similar gains from other kinds of diseases and issues, this is relatively cost-effective.

And we have studies of our own Medicare program that also tend to suggest that the pneumococcal pneumonia vaccine has been a cost-effective investment.

Senator **Durenberger**. Your testimony cites the deleterious effects of cigarette smoking on health, and a number of private companies and insurance companies are offering people economic incentives to encourage them to quit smoking to reduce the illness and promote disease prevention. Do you know whether the Department of HHS has ever considered a similar approach or would recommend a similar approach to us in terms of legislative strategy built into Medicare, for example?

Dr. **McGinnis**. Obviously there are a number of options that are considered, and many of them do involve legislative options. There has been no formal proposal of any sort to emerge from the Department along those lines, aside from the approach to providing labeling on cigarettes.

Senator **Durenberger**. Do you think they should?

Dr. **McGinnis**. I think that there are possible economic approaches to providing disincentives to smoking that the Department would be interested in considering. Again, it is a question of the best way to help people reduce smoking. There is no question that smoking is the leading preventible cause of death in this country. There is also no question that a lot of people are quitting smoking. Whether or not additional economic incentives are needed is something that I think we would need to study more carefully.

Senator **Durenberger**. Does the Department of HHS have a no-smoking policy in the Department?

Dr. **McGinnis**. We have a restricted smoking policy in conference rooms and open areas. Depending on the agency involved, we have a clean indoor air policy. For example, there is an effort to group smokers in certain areas, so that people who are nonsmokers are not unnecessarily exposed. The interest is in providing a general clean indoor air environment, following the lead of States like Minnesota, which have been very aggressive and have provided a lot of leadership in this area.

Senator DURENBERGER. How about following the lead of some private employers who just ban smoking entirely? Have you ever recommended that to the Secretary?

Dr. McGINNIS. No; I have not recommended that to the Secretary, though we have recommended and indeed many agencies are implementing a more aggressive clean indoor air policy. And I think you are quite right to point out the lead of some private sector organizations in this respect. Although, on the other hand, there is a much greater need throughout most of the private sector than there is even at the Federal level. We are working extensively with a variety of private sector organizations to try to strengthen their own efforts.

Senator DURENBERGER. Do you know that the recently retired head of the Office of Personnel Management smoked that damned cigar of his wherever he went, including places like this? [Laughter.] I'm glad I didn't show up at the confirmation hearing. [Laughter.] I guess the point I am making is by example. I don't know that I am necessarily urging that we ban smoking, and that sort of thing, but, Lord, we ought to do something by way of example. I mean, I used to sit up here smoking my pipe from time to time, until it finally got through my head that I'm a lousy example of what I talk about. And yet, if the head of the Office of Personnel Management of the U.S. Government and 2½ million employees is going around with a stogy wherever he goes, what kind of an example does that set?

Dr. McGINNIS. I think you are absolutely right. For example, several of our Indian Health Service hospitals have indeed banned smoking in their facilities. It is largely a decentralized effort, in which we are trying to select those areas which are most important to provide that kind of an example. But we do need to strengthen our efforts in that regard.

Senator DURENBERGER. Dr. McGinnis, thank you very much. I have lots of other questions that we may propound to you, but thank you for the presentation, the thoroughness of that presentation, and for the work you are doing.

Dr. McGINNIS. Thank you.

Senator DURENBERGER. Our next witnesses are a panel consisting of Dr. Les Breslow, the director of the cancer control research at the Division of Cancer Control at UCLA and dean emeritus of the UCLA School of Public Health; Dr. Robert Kane, professor of medicine and public health at UCLA and senior researcher for the Rand Corp. in Santa Monica, and about to be the head of the School of Public Health at the University of Minnesota; and Dr. James C. Hunt, who has a previous association with the University of Minnesota—and so does Les Breslow, by the way. This is an unusual panel. I don't know how we happened to get all three of you together.

Jim Hunt is chancellor and vice president for health affairs, Center for Health Sciences at the University of Tennessee in Memphis.

Gentlemen, thank you for being here. As I indicated earlier, your excellent statements, which take longer than 5 minutes to deliver, will be made part of the record, and I will certainly appreciate your summarizing your statements in 5 minutes or less. Thank you.

Les?

STATEMENT BY LESTER BRESLOW, M.D., M.PH., DIRECTOR, CANCER CONTROL RESEARCH, DIVISION OF CANCER CONTROL, UCLA, JONSSON COMPREHENSIVE CANCER CENTER AND DEAN EMERITUS, UCLA

Dr. **Breslow**. Thank you, Mr. Chairman.

I want to note that my appearance here today is solely that of an individual.

When Congress enacted Medicare in 1965, it followed closely the prevailing health insurance practice. That meant excluding preventive services.

Since 1965, several developments affecting health service have vastly changed the situation. First of all, the health of the American people has substantially improved. It has improved particularly among persons over 65 years of age.

By the measure of life expectancy, for example, the health of persons beyond 65 years is improving more than twice as fast as it was during the first half of the century. Also, health is currently improving as much after age 65 as during all of life up to that time.

The previous fatalistic notion that elderly people are largely doomed to several years of misery before death is giving way to a more realistic and, fortunately, optimistic appraisal of health after 65. Not only are older people living longer, but they are living with at least as good health as that enjoyed by older people formerly.

Second, these health improvements are due largely to prevention. For example, the decline in mortality from cardiovascular disease, which has been the leading health advance over the past 20 years, is attributed by the former Director of the National Heart, Lung, and Blood Institute largely to lifestyle changes. He says it is clear we must focus on prevention as a goal for the next 30 years.

In setting cancer-control objectives for the year 2000, the National Cancer Institute is properly depending heavily on preventing much of the cancer that now causes one-fifth of all deaths.

A study in Alameda County, CA, has shown that people who have followed good personal health practices die at less than 40 percent of the rate of persons who follow a smaller number of those same health practices. Most important, a strong, steady relationship between health practices and mortality prevailed definitely up to age 75, and apparently, though not quite as certainly, beyond age 75.

Industry has already taken note of the possibilities. Probably the fastest-growing aspect of health service today is health promotion at the workplace. It makes good sense to overcome health risks such as cigarette smoking and physical abnormalities such as high blood pressure.

Major medical organizations are likewise showing new and more favorable attitudes toward prevention.

Some people allege that the health damage from cigarette smoking, obesity, and the like, is already done by age 65, and that personal health habits thereafter are of no consequence. We found in Alameda County no evidence among older persons a diminished hazard associated with cigarette smoking, physical inactivity, deviation from moderate weight.

Senator DURENBERGER. Do you mean they can get better, or they can't?

Dr. BRESLOW. The findings are that the association between these health practices prevails as strongly after age 65 as before.

Senator DURENBERGER. You get an extra minute, now.

Dr. BRESLOW. OK. Thank you. [Laughter.]

We also have specific detection procedures such as the Papanicolau smear, mammography, which are relatively neglected among women over 50 and especially over 65 years of age. A great deal remains to be achieved after the age of 65 by medically guided exercise, nutrition, and other health habits, and by the detection and treatment of several fatal as well as nonfatal conditions.

You are going to be hearing more today about the change in attitude of the health insurance companies that now are aggressively exploring the incorporation of preventive services into their policies. They have embarked upon a study of payment to groups of physicians for health-promotion, disease-prevention services that is highly promising in regard to the acceptance by patients, by physicians, and even the very reasonable cost that is involved in such preventive services.

The outlook for extending life and health after 65 is indeed really great. People are now passing the 65 mark largely in good health, and it is possible for most of them to keep it.

Now, finally, in order to realize the potential of good health for people after 65, it is obviously necessary to assure appropriate preventive services. While the precise scope of such preventive services will have to be determined, preferably by expert consultants to the Congress, that task really will not be too difficult. Consensus is growing in medical and insurance circles that a package of preventive services to include both health counseling and a relatively few simple procedures can be established for periodic monitoring of health just as well after 65 as before. Such periodic monitoring would provide the basis for preventing disease and promoting health.

One approach would be to offer a clearly-defined set of services to all persons as they become eligible for Medicare. These services would be designed as the basis for health guidance, regarding such items as height, weight, blood pressure, and blood cholesterol level. Physicians and their associates would then be in a good position to advise the individual about the specific actions necessary to preserve and even improve health. Having such a health evaluation accompanied by appropriate health information—and I would emphasize that—would constitute a highly desirable entry to Medicare eligibility. It would be desirable, of course, to repeat this kind of health monitoring periodically after the entry examination. The Medicare program cost of such health monitoring which I could detail, would be really quite reasonable.

Senator **Durenberger**. Thank you very much.

Dr. Kane.

[Dr. Breslow's written testimony follows:]

Testimony 14 June 1985

Submitted to

Health Subcommittee, Senate Finance Committee

by Lester Breslow, M.D., M.P.H.*

Mr. Chairman,

I am Lester Breslow, Professor and Dean Emeritus, UCLA School of Public Health. Although that indicates my current academic position, and I am affiliated with several scientific and professional organizations concerned with health, my appearance here is solely that of an individual. It does not represent any organization.

Beginning today, your consideration of incorporating preventive services into Medicare is a very important milestone. That program has already benefited tens of millions of Americans in respect to curative medical services, and it is timely to examine whether and how preventive services should be added.

When Congress enacted Medicare in 1965, it followed closely the prevailing health insurance practice. That meant including reimbursement for diagnostic and treatment services, but excluding preventive services. Since that time, however, several developments affecting health service have vastly changed the situation. Reviewing and analyzing the changes should provide insight into the question of providing preventive services in Medicare.

First of all, the health of the American people has substantially improved since 1965, and particularly among persons over 65 years of age.

Second, consensus is growing that the recent improvements in health are due largely to preventive actions by rather than to technological improvements in diagnosis and treatment. This view concerning the effectiveness of prevention rests on an expanding body of scientific knowledge.

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*Professor and Dean Emeritus, School of Public Health, UCLA

Third, America's major insurance companies are vigorously exploring whether and how to incorporate preventive services into their policies. That exploration is encouraging, including findings among persons over 65.

Fourth, the notion that extending life inevitably brings higher medical costs for those at the end of life is faulty.

Finally, the outlook for extending health and minimizing disease through the later decades of life is promising. Advance in this direction could be accomplished with relatively minor outlay of funds by Medicare, and there is substantial basis for anticipating a long-range saving of funds by prevention.

Following this reasoning it is timely to consider specific action that will provide to Medicare beneficiaries the type of preventive services that are increasingly available to the rest of the population, with great advantage to health.

IMPROVEMENT IN HEALTH BEYOND AGE 65

In considering the issue it is important to examine recent trends in the health of elderly Americans. One measure of health is life expectancy, the 50-50 chance that a person of a given age will live a certain number of years beyond that age. During the first half of this century life-expectancy at birth increased 21 years, from 47 to 68 years (Table 1). That is an increase of four years per decade. During the same time period, however, persons at age 65 gained only two years, that is 0.4 years per decade. For the second half of the century the trends are vastly different. From 1960 to 1980 a child at birth gained four years in life-expectancy.

That is two years per decade, just half the rate of increase that occurred during the early part of the century. A person aged 65, however gained two years during 1960-1980 or one full year per decade. By the measure of life-expectancy, therefore, the health of persons beyond 65 years of age is improving more than twice as fast as it was during the first half of the century. Also, health is currently improving as much after age 65 as during all of life up to that time.

Furthermore, the previous, fatalistic notion that elderly people are largely doomed to several years of misery before death is giving way to a more realistic and, fortunately, optimistic appraisal of health after 65. Not only are older people living longer but they are living with at least as good health as that enjoyed by older people in former years. The common notion that people are avoiding early death only to experience more suffering from illness after age 65 is not borne out by available data. Although the information concerning morbidity and disability is not as complete and clear-cut as mortality information, the amount of restricted activity and of bed disability among persons 65 and over continued at about the same level in 1980 as in 1965.(1)

HEALTH IMPROVEMENTS DUE TO PREVENTION

The improvements in health during the past few decades, represented by extensions of life expectancy, are increasingly considered due to prevention. For example, decline in mortality from cardiovascular disease, which causes about half of all deaths in our country, has been leading the health advance over the past 20 years. Robert Levy, former Director of the National Heart, Lung and Blood Institute, in reviewing the sharp drop in cardiovascular deaths concludes that "risk factor and lifestyle changes deserve a good portion of the credit ... (and) ... it is clear that we must focus on prevention as a goal for the next thirty years."(2) Also, a recently completed landmark study of myocardial infarction, a form of cardiovascular disease, concluded that "the major source of the decline has been a reduction in the incidence of the disease; fewer cases have been occurring, rather than that people with the disease are being treated more effectively.(3) The investigation, among Dupont employees, thus shows that prevention is mainly responsible for the improvement.

Furthermore, in setting cancer control objectives for the year 2000 the National Cancer Institute is properly depending heavily on preventing much of the cancer that now causes about one-fifth of all deaths. The NCI also relies on screening, "secondary prevention", for an additional step toward the objectives, because early detection by screening means better cure rates.(4)

Attributing to prevention a large portion of recent and possible future health improvement, including that among older persons, is consistent with an expanding body of pertinent scientific knowledge. For example, a study in Alameda County, California, has disclosed that people who follow good personal health, preventive, practices experience a much lower mortality rate than those with poor health practices (Table 2). Over a nine-and-a-half year period persons who ate moderately, usually slept 7 or 8 hours, exercised at least moderately, ate regularly, used alcohol moderately or not at all, usually ate breakfast, and did not smoke -- such persons died at less than 40 percent the rate of persons who followed only three or fewer of these health practices. Perhaps of special interest to your Committee, a strong, steady relationship between health practices and mortality prevailed not only during young and middle adult life but also definitely up to age 75 and, apparently but less certainly, beyond age 75.

That kind of evidence, of course, reflects what people do themselves in their personal lives. Physicians and others providing preventive health services, however, can influence how people eat and drink, quit cigarette smoking, and otherwise follow good health practices.

Industry has already taken note of that fact. Probably the fastest growing aspect of health service today is health promotion at the workplace.(5) Industry is finding that it makes good health and good economic sense to offer all employees, as executives have been provided for some years, professional services for detecting and overcoming health risks. These health risks include both certain personal habits such as cigarette smoking, and physical abnormalities such as high blood pressure and high blood cholesterol levels.

Until recent years senior, leading physicians taught younger ones that learning about prevention was boring and essentially useless. Now young physicians seem to be getting a different message. A California Medical Association survey of students and recent graduates of California medical schools has disclosed that from one-half to three-fourths of the classes graduating 1975-1984 agree that "medical education should place more emphasis on preventive and less on curative aspects of medical practice."(6) Only about one-sixth disagreed and the rest were indifferent.

Major medical organizations are likewise showing favorable attitudes toward prevention, including services for persons beyond 65. For example, the American College of Physicians has published a summary of various recommendations for specific features to be included in periodic health examinations for persons from age 16 to 75+.(7)

Some people question whether prevention is pertinent to older persons. It is alleged, for example, that the health damage from cigarette smoking, obesity and the like is already done by age 65 and that personal health habits thereafter are of no consequence to health. We have examined that issue in the Alameda County study. We found no evidence for diminished risk among older persons associated with cigarette smoking, physical inactivity, and deviation from moderate weight.(8) When one also takes into account baseline health status, sex and race, the impact of health habits is essentially the same on older persons as on young persons. Furthermore, quitting cigarettes, by older as well as by younger persons, lowers health risk. These findings from California are generally consistent with those from Duke University.(9) One study is deviant in regard to total mortality being associated with health habits in the elderly.(10)

Knowledge concerning the health significance of many previously undetectable or disregarded physical changes is growing rapidly. That knowledge is becoming the basis for highly important preventive health services. For example, appropriate handling of relatively "minor" degrees of high blood pressure is now saving thousands of lives from cardiovascular disease. Periodic surveillance of blood pressure and some associated factors such as obesity, together with follow-up care of those at risk, has therefore become an important health service.

Detection of cancer in its early stages, providing a better opportunity for cure, has long been a pillar of cancer control. Relatively inexpensive technology for cancer detection is rapidly improving and medical authorities are urging its widespread application. The Papanicolau smear has provided the means for bringing uterine cervix cancer under control among younger women. Older women, especially those who are poor and not well educated, suffer a disproportionately high number of deaths from cervix cancer, about 2,000 per year, because they have been neglected in applying this preventive service. Whereas four-fifths of women at all ages 18-64 receive Pap smears regularly, less than half the women 65 and over receive that service.(11) Mortality from cancer of the breast can be curtailed to the extent of about one-third among women over 50 years of age through use of mammography and possibly other means of detection. Again, older women are the most neglected. Findings from a recent study indicate a possible technological breakthrough in detection of colon cancer, the second leading fatal cancer.(12) If verified, that will make still more feasible the control of cancer through early detection.

It is not possible in this presentation even to list all the preventive services (vision, hearing and foot care come to mind) that are important to health. One point, however, should be emphasized. A great deal remains to be achieved after the age of 65 by medically guided exercise, nutrition, and other health habits and by the detection and treatment of several fatal as well as non-fatal conditions. While it is obviously desirable to avoid high blood cholesterol levels, maintain physical fitness and normal blood pressure and find cancer early during the younger years of life, such effort should be extended throughout life. There is no reason to abandon preventive health services at age 65 when an average of 17 years of life, often some of the best years, remain.

CHANGE IN ATTITUDE OF HEALTH INSURANCE COMPANIES

Highly relevant to incorporating preventive health services into Medicare is the sharp change in health insurance company's attitudes toward such services for the whole population, young and old. Although previously resisting preventive services as a component of health insurance benefits, during recent years the insurance industry has been vigorously exploring the provision of such services in regular medical care. It is my understanding that you will later today be hearing from the health insurance industry directly. Some findings of the exploration to date, however, are so pertinent to my testimony that I want to note them here.

In 1980 a consortium of life and health insurance companies (INSURE) embarked upon a study of payment to groups of physicians for health promotion/disease prevention services in a lifetime health monitoring program.(13) A clinical model developed from reports in the medical literature and professional consensus is being applied in the form of guidelines for dealing with patients in 10 specific age periods throughout life. Tests in several communities around the United States are underway. Early results indicate that patients of all ages, as well as their physicians, readily adapt to the format; the patients especially express great enthusiasm; and favorable impact on risk factors occurs. The average cost per actual patient visit, combining experience in several cities, was $72.99 for all ages. It was $139.90 for persons 60-74 years of age and $130.08 for those 75 and over. These cost figures include payment for the time physicians spend in counseling patients. Several common technical procedures such as routine chest x-ray are not included because they merely add to the price without demonstrable value. The costs mentioned should be interpreted bearing in mind that the model calls for visits at varying intervals according to age. For example, there can be a visit every two years at ages 60-74, and every year thereafter. Of course, not every eligible person obtains every allowable visit. Thus, in practice the actual program costs would be considerably lower than what might be inferred from the amounts cited above for a particular visit.

Further illustrating the growing commitment of the insurance industry to prevention, many companies offer a premium reduction to non-smokers similar to that long provided to persons of normal weight. That may be a useful thought for Medicare.

One can only speculate as to the factors involved in the new affinity of insurance companies for prevention. Growing eagerness of the American people and especially their business and labor leaders for expanding preventive services in the health system, as shown by a recent Harris poll, may be one element.(14) Competition from HMOs and from industry self-supplied services may play a role. One thing seems quite likely: guided by their usual actuarial estimates the insurance companies do not intend to lose money with preventive services. Perhaps again, those responsible for Medicare can learn from the private insurance industry.

SOME COST ASPECTS

Considerable misunderstanding of the facts about health services and their costs among the elderly confounds thinking about health insurance, and specifically Medicare cost implications.

For example, it is commonly thought that aging per se brings an increase in the number of physician visits and other aspects of health service. As a matter of fact, the average number of physician visits does not increase with age per se. While physician visits are, of course, only one measure of health service they may also reflect the distribution of other services. At every age from 20 to those over 65 the number of physician visits is essentially similar for persons with a given degree of health (Table 3). Persons with severe disability visit physicians more frequently than persons with lesser disability, and the latter more frequently than persons with no disability -- irrespective of age. People with no disability, no chronic conditions, and no symptoms visit physicians least of all; and such people who are over 65 visit physicians no more than those under 65. Thus it is not age that determines the frequency of visits but the degree of health. To the extent that health is better, regardless of age, the average number of physician visits declines.

Another common but mistaken notion was expressed recently in a prestigious medical journal, as follows: "Preventive medicine ... increases costs .... It is the objective of preventive medicine to maintain health and well-being and to postpone death. But the longer death is postponed the more expensive it becomes. The older the population, the more dialyses, the more transplantations, the more intensive care, and the longer the hospitalizations."(15) The facts from Medicare itself contradict that view. In 1978, for example, the average Medicare reimbursement during the last year of life (a common measure of the "cost of dying") for persons who died at age 67-69 years was $6,354.(16) For those 70-74 years it was $5,897. The Medicare "cash" of dying, that is, payment during the last year of life, in fact declines steadily with age. Average reimbursement drops to $3,598 for persons 85 years of age and older. Medicare costs for dying persons over 85 are thus only a little more than half the amount expended for those who die in their late 60's.

OUTLOOK FOR EXTENDING LIFE AND HEALTH AFTER 65

During the latter part of this century not only are more people reaching the age of 65, but once they come to that point they are living longer. Furthermore, with current and expanding knowledge of how to maintain and promote health the outlook is for substantial enjoyment of the extended years of life. The concept that miserable health must accompany the later years is outmoded. People are passing the 65 mark largely in good health and it is possible for most of them to keep it. Seven out of ten persons over 75 years of age, as well as those 65-74, assessed their health as excellent or good.(17) Less than one-tenth assessed their health as poor. Just as people and their physicians have learned and are still learning to prevent disease in the younger years of life, the same can be done by and for older persons. Most people do and more could have good health beyond age 65.

PREVENTIVE SERVICES IN MEDICARE

In order to realize the potential of good health for people after 65 it is obviously necessary to assure appropriate preventive services. That should be done as a part of Medicare. While the precise scope of such preventive services will have to be determined, preferably by expert consultants to the Congress, that task will not be too difficult. Consensus is growing in medical and insurance circles that a "package" of preventive services to include both health counseling and a few relatively simple procedures can be established for periodic monitoring of health, after 65 as well as before. Such periodic monitoring by primary care physicians would provide the basis for preventing disease and promoting health. We learned long ago that lesson for pregnant women and children. The practice of periodic health monitoring is now being extended to the adult years. I believe that it is timely to incorporate it into Medicare.

One approach would be to offer a clearly defined set of services to all persons when they become eligible for Medicare. These services would be designed as a basis for health guidance by a primary care physician. Examples of items to be considered for the entry evaluation are height, weight, blood pressure, blood cholesterol level, mammography, vision and hearing tests as well as determination of smoking, alcohol use, eating, exercise and other habits that are pertinent to health. Physicians and their associates would then be in a good position to advise people about the specific actions necessary to preserve and even improve health. Having such a health evaluation, accompanied by appropriate health information, would constitute a highly desirable entry to Medicare eligibility.

Such service and information would give people as they become eligible for Medicare the opportunity and encouragement to establish or confirm patterns of behavior, and relationships with primary care physicians, that would be conducive to health. It would help reorient people and their physicians to greater emphasis on prevention in health service, rather than reliance on trying to diagnose and treat disease after it has progressed to an advanced stage.

It would be highly desirable, of course, to repeat this type of health monitoring periodically after the entry examination.

The Medicare program cost of such health monitoring, if patterned after the model which the private insurance industry is now exploring, would be considerably less than five percent of present Medicare expenditures. Highly significant improvement of health can be expected to emerge from this preventive approach, far greater, I would say, than from the expansion of Medicare costs in recent years for high-technology diagnostic and treatment services.

People would be getting something very useful to health for the money expended, and Medicare would have the prospect of cost-savings down the road when health is maintained to the maximum possible degree.

Table 1

Life Expectancy at Ages 0 and 65, United States, Selected Years

	At Birth	Added	At Age 65	Added
1900	47.3		11.9	
1950	68.2		13.9	
		20.9 ====		2.0 ===
1960	69.7		14.3	
1980	73.7		16.4	
		4.0 ===		2.1 ===

Source: Health, United States 1983. DHHS Pub. No. (PHS) 84-1232. U.S. Gov't Printing Office, Dec. 1983, Washington, D.C.

Table 2

Percentage Dying in 9 1/2 Years, by Health Practice Score

Health Practice Score	Age-Adjusted	Under 45	45-54	55-64	65-74	75+
Men (Age in 1965)						
0-3	20	5	19	38	63	88
4	14	2	11	20	49	95
5	13	1	10	27	49	75
6	11	2	8	19	37	62
7	6	0	2	9	23	47
Total	13	2	10	22	44	72
Women (Age in 1965)						
0-3	12	3	7	20	43	75
4	11	2	6	18	35	69
5	8	2	2	12	33	57
6	8	2	7	9	24	47
7	5	0	2	8	7	75
Total	9	2	5	13	27	59

Source: Breslow, L. and Enstrom, J.E. Persistence of Health Habits and Their Relationship to Mortality. Preventive Medicine, 9, 469-483, 1980.

Table 3

Average number of physician visits past year by physical health status, 1974

							No disability, chronic conditions or symptoms and	
	Total	Severe disability	Lesser disability	Two or more chronic conditions	One chronic condition	Symptoms only	Moderate or low energy	High energy
Total	4.6	14.4	6.9	5.8	3.9	3.2	2.0	1.4
Men								
Total	3.4	13.0	5.3	4.0	3.4	2.3	1.7	1.1
20-29	2.6	8.3	0.8	2.9	3.4	3.0	2.1	1.2
30-44	2.7	17.1	2.6	4.9	2.6	2.1	1.4	1.4
45-64	4.0	12.3	7.3	3.9	4.0	1.9	1.4	0.8
65+	5.4	12.8	4.2	4.2	3.9	2.6	1.8	0.6
Women								
Total	5.7	15.1	7.9	7.0	4.5	3.9	2.3	2.0
20-29	5.1	22.7	11.2	9.6	5.0	4.3	2.8	1.7
30-44	4.8	17.5	7.9	10.2	5.6	3.3	2.2	2.8
45-64	6.1	15.1	8.2	6.0	3.4	4.3	1.7	1.5
65+	7.0	13.0	6.2	5.3	3.7	2.7	1.3	2.1

Source: Unpublished data. Human Population Laboratory, California Department of Health Services.

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8 July 1985

Edmund J. Mihalski, C.P.A.
Deputy Chief of Staff for Health Policy
Committee on Finance
United States Senate
Washington, D.C. 20510

Attn: Ms. Shannon Salmon

Dear Mr. Mihalski:

In response to your letter of 18 June 1985 concerning my 14 June 1985 testimony at the Subcommittee on Health hearing regarding Health Promotion and Disease Prevention, I am pleased to respond to your questions.

1. The apparent discrepancy between the information cited by Senator Packwood in his question and the information I cited in my testimony is that Senator Packwood is referring to the average annual Medicare reimbursement for all enrollees, whether surviving or dying, whereas I was referring to payments only for those in their last year of life. The latter payments are a common measure of the "expense of dying." Payments do tend to go up as people enter the dying period; more care is usually required then. The point I was making is that the common notion that the "expense of dying" increases with age is not true. According to Medicare data, payments during the last year of life actually decline with age:

Average Reimbursement per Enrollee
During Last Year of Life Medicare, 1978*

67 years or over	$4,527
67-69 years	5,801
70-74 years	5,466
75-79 years	5,056
80-84 years	4,274
85 years or over	3,285

NOTE: Data are expressed in 1978 dollars.

(*) Lubitz, J. and Prihoda, R. The Use and Costs of Medicare Services in the Last 2 Years of Life. Health Care Financing Review. Spring 1984, Vol. 5, No. 3, p. 117-131.

Among those who survive into the later years, average annual reimbursement for enrollees as a whole does increase. A substantial--probably the major--portion of that increase, however, is due to the cost of care for conditions that are preventable. These include, for example, diseases that result mainly from high blood pressure, obesity, cigarette smoking, and lack of adequate exercise and nutrition. If preventive action to minimize these factors were carried out after age 65 as well as before, much of the disease between 65 and 80 or 85 would be avoided, thus reducing Medicare payments during that period of life. Furthermore, as noted above, it is less expensive to Medicare for one to die at age 80-85 than at 65-70.

Obviously the longer people stay alive after age 65, and they are staying alive longer, the more years Medicare is obligated for their medical benefits and the total expenses go up. The failure to provide preventive services, however, adds to the expense in two ways. First, it permits the occurrence of much disease and the Medicare cost of paying for its care, disease that could be avoided. Second, the failure to provide preventive services denies the opportunity for the lower "expense of dying" that occurs as age advances.

In response to your specific request for "suggestions about how to design a demonstration which will provide empirical data on the cost effectiveness of preventive care for the elderly," I do have a suggestion. I advance it on the basis of experience over the past few years in helping to design demonstrations by the insurance industry and by other major industries to obtain data on the effectiveness, including cost effectiveness, of preventive services both before and after age 65.

Briefly, for the elderly I would propose a study of the health and medical cost experience of a sample of Medicare enrollees for whom preventive services were reimbursed by Medicare, contrasted with the experience of a comparable sample of Medicare enrollees for whom preventive services were not reimbursed. It would be necessary to define the services to be provided, to determine how they would be provided, to offer them with appropriate information to a sample of Medicare enrollees, to keep adequate statistical data, and to maintain the demonstration for several years. If Senator Packwood is interested, I would be pleased to provide more detail.

2. To the second question, concerning the lesson we can learn from the "new affinity" of insurance companies for expanding preventive services, I would respond that we can learn the feasibility--and increasingly the effectiveness--of providing preventive services. We can also learn something about how to study the issues involved. Until recently insurance companies have eschewed the provision of preventive services as a part of their benefits. Now in the INSURE project of the Industry-wide Network for Social, Urban and Rural Efforts, 1850 K Street, N.W., Washington, D.C. 20006, they are carefully reexamining the matter and have already learned some things. Medicare, when it started in 1965, followed the insurance company pattern of not providing preventive services. Now Medicare is leading the insurance companies in many respects, but in regard to preventive services Medicare is lagging.

It is astonishing that as a nation we continue to spend billions in Medicare on "curative" services of dubious value but have not undertaken even to determine the benefit of preventive services.

Senate initiative in this matter is much needed.

Sincerely yours,

Lester Breslow, M.D., M.P.H.
Professor of Public Health

LB:sh

STATEMENT BY ROBERT KANE, M.D., PROFESSOR OF MEDICINE AND PUBLIC HEALTH, UCLA, AND SENIOR RESEARCHER, THE RAND CORP., SANTA MONICA, CA

Dr. KANE. Thank you very much, Mr. Chairman. I am looking forward to my change of work location to Minneapolis. I must tell you that in preparation for my new task, the hardest thing I have done to date is to give up my pipe; so we share that in common.

I would like to just summarize a few important points that reemphasize some of the points made by Dr. Breslow.

Beyond the clear need for prevention within the scope of Medicare, it is also important to recognize that the groups covered by Medicare are heterogeneous, and that preventive programs have to be targeted to appropriate subgroups within that general target group of the Medicare population.

One needs to think about the functionally disabled, whose needs are different from those of the predominantly well elderly. One should think about prevention under a Medicare strategy as going beyond traditional concepts to address functional disability, and particularly to address iatrogenic illness, which is probably the most preventable disease of the elderly covered by Medicare.

Many of the chronic disease-prevention programs that we are talking about involve changing the behavior of both patients and providers. As we look at the way doctors treat patients under Medicare currently, it is distressing to note that in national samples our data show that the older the patient, the less time a doctor spends with the patient in any given encounter.

So what we are talking about here are changes that require changes in provider behavior much more than changes that require new technologies. We know what to do; we simply are not doing it.

A substantial component, then, of Medicare-covered prevention is going to be most effective if it is linked closely to some kind of a system of meaningful primary care. We need physicians who are knowledgeable about what to do with elderly patients. Again, our studies suggest that physicians simply don't know the difference between treating an older patient and a middle-aged patient.

So much of the problems we want to see addressed are problems which require paying closer attention to functional problems that are not usually the focus of traditional physician concern; here I am talking about things that run the gamut from vision, hearing, to depression. This is particularly complicated in a fee-for-service reimbursement system, where we are challenged to find a system that will not lay itself open to easy exploitation by providers.

Because both the elderly and the chronically disabled have been excluded from most of the preventive research up to now, they face a double penalty, if you will. On the one hand, the conclusions that we can offer about the efficacy of preventive interventions for these groups must primarily rely on extrapolations of data from younger groups. At the same time, it would be unfair to penalize these groups simply because we have not given them the appropriate attention they deserve and therefore lack the database on which to proceed.

I would like to recommend a four-point program which I think represents at least a step toward the kinds of things that need to be done. We want a response under Medicare that would not be simply an endorsement for spending more money inefficiently, but would prevent the kind of exploitation that a fee-for-service system encourages.

I propose an approach that we call primary prevention contracting. Under the system a Medicare patient would identify a physician as his primary-care provider. Physicians agreeing to serve in that role would make a commitment to taking the responsibility for prevention. When the patient and the physician have indicated in a simple written contract that they have entered into this type of agreement, the physician would receive an annual bonus, which would be roughly equivalent to the fee that he would ordinarly receive for a comprehensive visit; such a fee would be independent of the usual deductibles but would be subject to copayments.

The annual bonus is not intended to replace visit charges but to supplement them as a true bonus. In return for this fee, the physician would agree to provide at least a specified minimum package of services, quite compatible with what Dr. Breslow has indicated, but also would agree to counseling about inappropriate habits and to completing a simple checklist that would indicate his consideration of commonly overlooked problems.

In addition to that step, about which I can give more details, I also suggest that there is a very real need for better information for seniors, particularly information to counter the kinds of information that is currently being offered by a variety of hucksters selling various types of preventive services.

Third, I think we need a specialized prevention centers for elderly persons. They would emphasize functional assessment for those who are disabled, where we could make significant savings; randomized controlled trials have already well-documented the ability prevent unnecessary hospitalization and nursing home use.

Finally, I believe we do need more research in the efficacy of prevention for the elderly, and I believe that S. 359 represents an important first step in seeing that that kind of research is carried out.

Thank you.

Senator DURENBERGER. Thank you.

Jim Hunt.

[Dr. Kane's written testimony follows:]

TESTIMONY OF ROBERT L. KANE, MD BEFORE THE SENATE FINANCE COMMITTEE ON HEALTH PROMOTION AND DISEASE PREVENTION

JUNE 14, 1985

Mr. Chairman, Members of the Committee:

My name is Robert Kane. I am currently a Senior Researcher at The Rand Corporation and Professor of Medicine and Public Health at UCLA. I will shortly take up new duties as Dean of the School of Public Health at the University of Minnesota. However, I wish to make clear that the testimony I am providing represents my own opinions and does not reflect official positions of any of the institutions with which I am affiliated.

For the past several years, my colleagues and I have had the opportunity to review research done on prevention in the elderly. I have undertaken this work as part of other research examining the way in which physicians and other health professionals provide care for older persons. I am heartened at the Committee's interest in an important area of health care that has been conspicuously absent from Medicare. I would like to share with you some ideas about how such care might be organized in a manner that will maximize its effectiveness while averting the potential for inappropriate exploitation. As I hope to explain, the current fee for service reimbursement system for physician services provides perverse incentives to thwart many of the goals sought under the new emphasis on prevention. Building a prevention program on this payment system may increase costs without necessarily improving care. An effective approach to prevention for the elderly must recognize the variety of persons addressed and respond with a similarly multifacted program.

Medicare addresses two population groups noted for increased prevalence of chronic disease, namely the elderly and the chronically disabled. It is important to recognize at the outset that the elderly represent a heterogeneous group of individuals. Our social definition of old age as a phenomenon that begins at age 65 lumps together a majority of very well individuals with an important minority who are chronically impaired. We can expect very different results from preventive interventions targeted at very functional individuals from those targeted at elderly persons who need substantial amounts of assistance.

A few basic facts provide evidence of the heterogeneity among the elderly. According to the 1979 National Health Interview Survey, the number of adults per 1000 needing assistance from another person in one or more basic physical activities or home management tasks range from 70 in the 65 to 74 year old age group to 436 in the 85 and over group (Feller, 1983). Data from the National Medical Care Utilization Expenditure Study indicates that in 1980 over 60% of the elderly spent less than $500 per year on health expenditures (interestingly, this proportion did not change significantly with age); at the same time, 10% of the elderly spent over $3500 per year (Kovar, 1983). Any program that hopes to achieve readily observable benefits in terms of reduced utilization of health care services and disability must recognize the importance of targeting services correctly to provide the correct package of services to the correct recipients.

When we are talking about the elderly, especially the chronically ill elderly, we need to expand our definition of prevention and health promotion to include efforts to maximize functional abilities and personal autonomy. Any discussion of prevention among the elderly must also address the problems associated with iatrogenic disease. As we will note later in this testimony, the elderly are more vulnerable to a number of problems that are the by-products of medical treatment.

For the functionally active elderly, prevention certainly is as appropriate as in younger age groups. Particularly in light of the demographic trends which show an increase in life expectancy at age 65, the concept of investment in primary prevention is by no means misplaced among the elderly. Because of increasing incidence of a number of conditions with age, secondary preventive efforts aimed at early detection of asymptomatic problems are likely to yield even more positive results among elderly persons than any younger people.

All this makes it especially ironical that both the elderly and the chronically disabled have been systematically excluded from most prevention research. Although there is a strong theoretical basis for arguing that many types of preventive interventions should be effective in this age group, the paucity of empirical data leaves us in a position where we must base our contentions on extrapolations from younger age groups. However, it would be a double disservice to the elderly to delay an implementation of preventive activities until we had acquired the necessary research information to prove what common sense strongly argues. Such research is certainly necessary, but its absence should not be the basis for legistative inertia.

In some instances, preventive programs for the elderly, should rely on group activities and educational efforts targeted at the community, but many of the them require individual behavioral change on the part of the patient and his physician. Almost all of them require the physicians to spend more time with their patients. Here we confront one of the bitter truths of geriatrics. Research data has shown that physicians in various primary care specialties tend to spend less time with older patients than with younger patients. Using data from a large national study done in the late 1970s, we have looked at these trends. As shown in Table 1, the average amount of time spent by general practitioners, internists and cardiologists in an office visit decreases with the patient's age. Although the actual amount of difference in average times is not great, approximately a 10% difference, the very evidence of that trend toward decreasing time runs counter to common sense expectations. Older patients are known for having more problems, for having atypical presentations of disease, for having communication problems which make it more difficult to obtain clear histories and to communicate recommendations for treatment. Moreover, these differences persist even when various statistical techniques are used to correct for the complexity of different types of visits. Thus any program designed to enhance prevention among Medicare beneficiaries should aim toward encouraging doctors to spend more time with their patients. This action alone should reduce iatrogenic consequences.

At the same time, doctors need to know more about what to do for elderly patients. Only in the last several years have we mounted any kind of well organized educational programs for medical students and practicing physicians to educate them about the specific needs of elderly patients. Again drawing upon data from the National Survey of Physician Practices, we found that physicians were less likely to perform breast examinations or do pap smears on patients over the age of 65. At the same time the did not recognize the limitations of laboratory tests such as the glucose tolerance test in older patients or the need to be more attentive to clinical problems more common in the elderly, such as hypothyroidism.

The message here is that preventive strategies for the elderly should be targeted at promoting better physician care and closer attention to commonly overlooked problems than toward using high technology approaches. In almost all cases no very sophisticated technology is required to perform an important preventive service. Rather what is needed is the time and motivation to recognize a commonly overlooked problem, to take more care in avoiding an unnecessary drug, or to encourage a change in patient behavior, or finally, to provide some type of screening test of a fairly simple nature. Such activities are not glamourous but they are time-consuming. A system that pays a fixed amount per visit is hardly conducive to encouraging providers of care to spend more time with patients.

Types of Prevention

I would like to draw your attention briefly to four classes of activities where different preventive strategies seem capable of providing useful dividends in the elderly. For a fuller treatment of the efficacy of prevention in the elderly, I refer you to a review we did recently (Kane, Kane, & Arnold, 1985). The four classes of preventive activity I want to underline here are 1) primary prevention (activities undertaken before there is any manifestation of disease), 2) secondary prevention (activities undertaken to detect disease before it becomes symptomatic), 3) common problems in the elderly which respond readily to simply closer attention from physicians, and 4) a group of conditions that might be best thought of as iatrogenic consequences of traditional care.

Within the area of primary prevention, there are a number of activities that seem very worth considering for the elderly. Immunizations for influenza, for tetanus, and probably for pneumococcal pneumonia are readily available and easily given to older persons at risk. Convincing evidence is accumulating for the efficacy of controlling blood pressure reduce the risk of heart disease and stroke. Here the data indicate strongly the need for continuous control of blood pressure rather than for more efforts at detecting elevated blood pressure. Most of the elderly who are hypertensive know it. The issue is doing something about it. The problem here is trying to deal with a problem which is essentially asymptomatic by introducing treatments which may produce symptoms. The answer seems to lie in well organized, carefully monitored care built around a single primary care giver.

The other area where there is growing optimism that changes in health habits may produce major benefits is osteoporosis. Recently we have recognized the need for increasing recommendations for calcium in the diet of post-menopausal women and have begun to actively consider the advantages of low dose estrogen treatment to delay the onset of osteoporosis.

An area of behavior change which pays rapid dividends for older persons is ceasing cigarette smoking. Recent evidence shows that elderly chronic smokers can reduce their risk of coronary heart disease and increase cerebral blood flow in relatively short periods of time. Such preliminary findings justify more stringent efforts to encourage older people to discontinue these perverse habits. Again, much of the need is to overcome strong biases among professionals that once an individual reaches an age like 65, there is no point trying to do anything to change that individual's life style. Such mythology often is based on nothing more than stereotypic thinking.

Another area that needs more attention in the course of daily medical practice with the elderly is the environment, particularly the home environment. Physicians can use simple tools to alert the elderly patient and their families to common dangers such as inadequate lighting, loose rugs, other physical barriers. Such efforts may eliminate or reduce falls, a major source of hospitalization and mortality among the elderly.

In the area of secondary prevention, most of the techniques advocated for younger patients are very appropriate for older individuals. The incidence of cancer generally increases with age. Certainly, pap smears, breast examinations--self-examinations and mammography, and rectal examinations for prostate and colorectal cancer are all very appropriately targeted to older patients as well as younger ones. With the exception of mammography, none of these require expensive technology.

Closely linked to secondary prevention are a series of problems that, despite their major functional consequences, often do not attract the attention of physicians. Here I refer to such things as problems with vision, hearing and dentition as well as symptoms associated with depression, alcohol, and drug abuse. Many of the visual and hearing deficiencies of the elderly, but certainly not all, can be readily corrected with dramatic functional results. Similarly, adequate dentition facilitates both eating and communication as well as promoting a better sense of self-worth. The prevalence of all three conditions rises linearly with age. Each of these disabilities is readily identified, if only the clinician is alert and motivated to look for the problem. More subtle challenges are presented in the detection of depression and alcohol abuse among the elderly. Although there is some evidence to suggest that these problems are much more common among the elderly than would be acknowledged from review of typical medical records, it requires very specific and carefully probing and a sensitivity of the potential for a difficult presentation among the elderly patients. Once again these are important problems, not only because they produce substantial disability, but also because they are treatable. Data on both depression and alcohol abuse in elderly persons suggest that these conditions can respond dramatically to appropriate treatment.

The fourth area of concern is iatrogenic disease; these are problems created by medical intervention. The most notable is probably the adverse consequences of drug therapy. Elderly persons taking five or more drugs are in essence walking chemistry sets in which each new ingredient added may produce a whole series of interesting chemical reactions. Under the best of circumstances physicians may not be able to correctly anticipate all of the drug interactions that are possible, but without any system of uniform information about what drugs are being taken, which are prescribed by different doctors and which are purchased over the counter, there is little opportunity to prevent even the most blatant problems of drug misuse. Here the lack of a single primary care provider is most acutely felt. Other more subtle iatrogenic problems include the unnecessary labeling of individuals, particularly at times of behavior abnormalities too readily diagnosed as dementia or urinary problems too quickly pronounced incontinence. At a more subtle level, we would argue that many nursing home admissions may be in fact iatrogenic consequences of inadequate functional assessment. Data on the effectiveness of geriatric assessment units strongly suggest that more efforts at such assessment properly targeted to appropriate groups, can dramatically reduce the subsequent use of both nursing homes and hospitals.

Developing Prevention Programs for the Elderly

Under Medicare, prevention has not received its appropriate consideration. Even if we do not accord to an ounce of prevention its tradition 16-fold value over treatment, its funding under Medicare has been greatly neglected. At the same time, the response to this inattention should not be a simplistic endorsement of spending money inefficiently. It is easy to imagine how specific billed charges for various preventive services could be rapidly inflated to provide yet another means of exploiting Medicare to the disadvantage of the elderly and society in general. Effective coverage of preventive services under Medicare should provide positive inducements for primary care physicians to spend more time with older people and to perform those types of services most likely to yield benefits for older individuals. At the same time a number of preventive activities may be better performed under different auspices. For these reasons, I recommend a four-part strategy for prevention under Medicare.

1. Primary Prevention Contracting

Under this system a Medicare patient would identify a physician as his primary care provider. This physician must agree to serve in that role, including a commitment for taking a responsibility for prevention. When the patient and the physician have indicated in a simple written contract that they have entered into this type of agreement the physician would receive an annual bonus equivalent to a fee for a comprehensive visit (about $100). This fee would be independent of any deductible but would be subject to the traditional 20% co-payment such that Medicare's portion would only be $80. The annual prevention bonus is not intended to replace the visit charges currently handled under part B of Medicare. For this fee, the physician would agree to provide at least a specified minimum package of services including some of the basic screening activities noted, counseling about inappropriate health habits, and completing a simple check list form indicating consideration of commonly overlooked problems.

This approach is designed to remain consistent with the present fee-for-service approach of Medicare physician reimbursement. It does not solve all the problems and will require regulation and enforcement. It mandates an explicit commitment to prevention from both patient and physician but it cannot avoid mere paper compliance. It has the additional advantage of encouraging the development of primary care and thus minimizing at least some of the potential for iatrogenic consequences of uncoordinated care; but it does not address the related question of how to pay for currently uncovered services needed to remediate functional problems revealed by improved primary care (e.g., refraction, eyeglasses, hearing aids, dental care). It is certainly not a panacea, but it is an important step forward at a reasonable cost. The investment is less than 20% of the cost of an average Medicare hospital day.

2. Better Information for Seniors

There is a real need for clear information directed at senior citizens about various types of preventive activities. This information is needed not only to identify those behaviors and practices which could improve the older person's health status, but also to protect these elderly consumers from what amounts to fraudulent advertising on the part of unscrupulous promoters of devices and products. Here I refer to the exploitation of the elderly with regard to vitamins, special health preparations, natural foods, and whole host of devices sold in the name of preventing illness. Although there are a wide variety of potential print and broadcast media vehicles available to make good information available to older people, unfortunately this information tends to be less dramatic because of its more modest claims and thus less media-worthy. Modest amounts of money, equivalent to a fraction of a percent of Medicare hospital payments, could finance the production of appropriate health education to counter much of the misinformation peddled by hucksters and to reinforce basic principles of prevention by offering practical steps to change personal practices.

3. Specialized Prevention Centers for the Elderly

For those elderly persons who are already afflicted with chronic illnesses, the need is for geriatric attention with an emphasis on functional assessment. This service is probably best provided in the context of specialized centers staffed by individuals well trained in geriatrics. The results of randomized clinical trials suggest that such activities can pay substantial dividends in decreasing morbidity and health services utilization (Rubenstein et al., 1984). Medicare payments should cover such care explicitly when it is provided by certified centers.

4. Research on the Efficacy of Prevention in the Elderly

Although the general exclusion of older and disabled subjects from most intervention studies on prevention have produced a dearth of good scientific information about the value of such interventions for older individuals, this lack of data should not be used as an excuse for inactivity. However, there is a need to address this deficiency. At a minimal, the models now being implemented by the Food and Drug Administration which mandate testing of new products on elderly subjects should be emulated to require similar coverage for preventive interventions. That is to say, studies targeted at younger individuals should be required to include cohorts of older persons. The effects of these different age groups can be analyzed separately but we desperately need better information about efficacy in the elderly. At the same time we should be pursuing special studies developed for problems of old age. Again we have failed to spend even a fraction of our curative health care budget on meaningful research on prevention. There are sophisticated resources throughout the country in instituions like schools of public health to handle this kind of research. Legislation has already been introduced (S.359) to establish centers to carry out such intervention trials. Such activities are very timely and sorely needed, but their unavailability should not serve as a basis for inaction.

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TABLE 1: AVERAGE TIME (MINUTES) PER OUTPATIENT VISIT

Patient Age	General Practitioners	Internists	Cardiologists
45-64	11.5	19.2	20.5
65-74	11.1	18.1	17.6
75+	10.8	17.6	17.4

Responses to Questions from Senator Packwood

Follow-up to Testimony June 14, 1985
U.S. Subcommittee on Health,
regarding
Health Promotion and Disease Prevention

Robert Kane, MD

I.

Because Medicare does address functionally disabled individuals, preventive programs targeted toward such groups should be designed primarily to prevent the disability from becoming a handicap. Recent research on interventions like geriatric assessment centers have demonstrated that, for many functionally impaired elderly individuals, a careful evaluation and short-term therapy can prevent unnecessary hospitalization and nursing home utilization. This type of activity is particularly cost-effective. As we apply the concepts of prevention to this category of individuals, we need to broaden the definition to include prevention of this type of long-term incapacity.

Closely related to this type of prevention is another area of prevention, namely the prevention of iatrogenic disease. Here too, closer attention to thorough evaluation can prevent tragic and expensive consequences. Inappropriate zeal in too hastily applying a label such as dementia or incontinence can doom a geriatric patient to a long-term care institution when a correctable cause may be available on closer examination.

II.

The concept of primary prevention contracting is indeed intended as a renewable contract. The proposal has several advantages. Not only does it address an important component of geriatric prevention, namely the need for primary care, it also provides a mechanism by which to begin to regulate the provision of primary care. As such, there is indeed a need for appropriate penalties. Because both the provider and the beneficiary are intended to be active participants, the penalties for breach of contract must fall on both. For the provider, the most appropriate penalty would likely be some type of monetary fine. For the beneficiary, a more appropriate penalty would involve a loss of certain types of benefits. At the very least the beneficiary would not be eligible for similar coverage for some specified period of time, perhaps two years.

STATEMENT OF JAMES C. HUNT, M.D., CHANCELLOR AND VICE PRESIDENT FOR HEALTH AFFAIRS, CENTER FOR HEALTH SCIENCES, THE UNIVERSITY OF TENNESSEE, MEMPHIS, TN

Dr. HUNT. Mr. Chairman, I am James C. Hunt, chancellor of the University of Tennessee Center for the Health Sciences. I wish to thank you and the members of your committee for your interest in health promotion and disease prevention and for holding this important hearing.

I believe that interest in HPDP will yield important results, and I think it will parallel that which has been a result of the support of biomedical research in this country.

I understand that my written statement will be submitted to the record, and my emphasis this morning will be briefly centered around health professional education rather than the broad field which you have heard from my two predecessors here.

Mr. Chairman, I am a physician, an internist. I have long been interested in HPDP. An example of that has been my involvement in the National High Blood Pressure Education Program from its very outset, and this is a continued involvement, and I believe it to be the model national program in secondary prevention.

I am a native North Carolinian, and I learned that nutritional management of malignant high blood pressure could be accomplished long before there was any available drug treatment for high blood pressure. At Mayo Clinic, my colleagues and I also learned that nutritional management of end-stage renal disease was effective before we started dialysis and transplantation—kidney dialysis and transplantation—some 25 years ago, at the present time.

We also proved the effectiveness of having the nurse and nutritionalists and other paraprofessionals involved as health care team members in the delivery of illness care and wellness care at that time.

We did experience great frustration, because there were many disincentive factors, including the absence of methods of reimbursement of paraprofessionals and team members other than physicians and dentists in the delivery of such care.

In 1978 I moved to the University of Tennessee Center for the Health Sciences in order to develop a health science center campuswide team approach to educate health professional students in HPDP, and we are well on our way toward establishing a national model in that regard. Our Health Science Center in Memphis, where I am the chief executive officer, each year graduates more than 600 physicians, dentists, nurses, pharmacists, biomedical scientists, and allied health specialists. I am sorry to say that until very recently our graduates had only a traditional education. We taught them to be expert in illness care. Our current students still receive that excellent education in illness care, but we now also educate them in wellness care. They are trained in fitness and in wellness, and they are prepared for public service as strong advocates and practitioners of HPDP.

Our entire university family participates in the campuswide wellness education program. Students, staff, faculty, faculty members' dependents learn HPDP through the university health service. The university health service is staffed by senior faculty in nursing, dentistry, medicine, and pharmacy, and also by paraprofessionals. Seed money for this effort has been provided by the W.K. Kellogg Foundation. They believe in this enough that they have invested some $2 million in a startup effort.

The health service is responsible for the campus food service. Good nutritional habits are learned as a campus living experience. We have seen major behavioral changes in our students, our staff, and our faculty, so far in their eating habits.

The university health service is responsible for our athletic facilities. We have converted this into a fitness center under the supervision of an exercise physiologist.

Our health service as a learning center is accepted with enthusiasm by most of our students, also by a high percentage of our staff and faculty, and I am pleased to say that our fitness center is busy from 6 a.m. until 10 p.m., and we are going to have to build another because we don't have facilities to take care of the entire family now.

Why do we advocate HPDP on a health science campus? Well, we are concerned about the health of our own people. We also believe that we should have our own people serve as role models. We believe that there are enough health professionals to provide for illness care of the nation now, and that they should expand their service deliveries. We also realize that HPDP is an art and a science, and it must be accomplished by an interdisciplinary and a multidisciplinary team, and the health science center campus is the place to begin this.

We believe that wellness care is important to citizens of all ages. It is especially important to older citizens. Fitness and wellness will not prevent aging, but it will delay the process. The aging process depletes our natural strength and reserve; wellness and fitness will certainly help us resist the disease processes.

Wellness care must emphasize total care—emotional, mental, and physical care.

For many years the public has been benefited, I think, through the Congress' investment in biomedical research, with great rewards. I think the time has come for the public to invest in HPDP. I urge you to help those of us committed to HPDP to establish centers of excellence in wellness education, and in wellness care, and to promote the good health of all of our citizens; especially the health of older citizens will be benefited by a broad-spectrum approach to wellness education.

Thank you, Mr. Chairman.

Senator **Durenberger**. Thank you very much.

[Dr. Hunt's written testimony follows:]

STATEMENT OF

JAMES C. HUNT, M.D.

Chancellor

The University of Tennessee

Center for the Health Sciences

Memphis, Tennessee

Citizen Witness in Support of Health Promotion and Disease Prevention

June 14, 1985

Before The

Committee on Finance

United States Senate

Senator Bob Packwood, Chairman

Summary of Statement

James C. Hunt, M.D.

Mr. Chairman and members of the Committee:

I am Dr. James C. Hunt, Chancellor of the Center for the Health Sciences of the University of Tennessee and Professor of Medicine at the University of Tennessee College of Medicine in Memphis, Tennessee. As a practicing physician, medical school teacher, health sciences administrator, and for many years an active participant in the affairs of the National Heart, Lung and Blood Institue, I am especially grateful for this opportunity to ask your continued interest in improving the health of the American people.

My statement is described in detail and is appended. However, I would like to emphasize in a brief summary the following:

1. Biomedical research has brought forth a profound array of fundamental new knowledge during the past forty years largely through initiatives established by the National Institutes of Health and the National Science Foundation. The Congress of the United States deserves special recognition for these advances because of the strong support and encouragement provided to the biomedical research community. For decades, the Committee on Finance of the United States Senate has maintained a strong commitment to the advancement of new knowledge in the cause, cure and prevention of disease in our nation.

2. In the not too distant past, especially following World War II, a significant shortage of health professionals prevented appropriate access to health services in the United States. The Congress responded to the national need and again the Committee on Finance of the United States Senate helped lead this effort to educate and train an adequate number of health professionals.

3. Access to high quality illness care services in our country is now readily available to most Americans. In some geographic areas, segments of our population, especially the elderly and the economically disadvantaged, are still underserved. However, these needs could be fulfilled with better administration of available programs and services. The shortfall is in no way a result of inadequate support from the Congress and results largely from the need to establish more adequate administrative supervision and application of available resources and manpower.

4. Although the application of new knowledge to the treatment of many of the dread diseases of mankind has resulted in decreased suffering and improved survival, especially for persons with cancer and infectious diseases, little has been accomplished in the prevention of disability and death for many persons with degenerative disease problems and in the delay of the aging process. A notable exception has been the favorable outcomes resulting largely from the National High Blood Pressure Education Program (NHBPEP). This Herculean effort from a broad array of professionals, industry, volunteer agencies, and individuals is at least partially responsible for the almost thirty percent decrease in heart attack death rates and an almost fifty percent decrease in stroke death rates during the past decade. Few would debate that the NHBPEP has demonstrated the effectiveness of secondary prevention. Indeed, this is the model national program.

5. Effective translation of available biomedical scientific knowledge to primary prevention has not yet been accomplished, especially for older citizens. We have conquered polio and smallpox and can prevent most of the diseases of childhood, but we have not appropriately applied available knowledge to the cure and prevention of the degenerative and self afflicted diseases of adults and older Americans. Many have sounded the clarion call for prevention but few have demonstrated an understanding of the concept and even less are willing to lead the charge for Health Prevention and Disease Prevention (HPDP).

6. Many of the health problems of adult Americans, especially the elderly, are in a large part a result of the lifestyle of our citizens. The health professional community and the health service industry have not adequately concerned themselves with HPDP in the adult population. To accomplish HPDP, a profound behavioral change is necessary in the health professional community and especially for the public which we serve.

7. Is the American public willing to accept the concept of HPDP and pay the price? Individual citizens are changing their behavior and are adapting to more healthy lifestyles with improved prevention and enhanced health. There is a strong motivation to accomplish improved health habits. Unfortunately, the health professional community has not led this effort. To date, there have been few, if any, motivating factors to stimulate the health professional provider.

8. We at the University of Tennessee Center for the Health Sciences (UTCHS) are convinced that the health professionals of today and tomorrow should, and must, be equally concerned with Illness Care and Wellness Care. Wellness care can be effective only through the application of HPDP. UTCHS is actively involved in a major change in health professional education, patient education and public education to enhance HPDP. We are convinced that the professional expert in Wellness Care will have a market for these services with appropriate reimbursement and other rewards.

9. The Colleges of Allied Health Sciences, Dentistry, Pharmacy, Medicine and Nursing and the Graduate School of Medical Sciences at UTCHS have initiated a campuswide commitment to the education of all of our health professional students in Illness Care and in Wellness Care. The laboratory for that effort is in our newly initiated University Health Service. With financial support from the W. K. Kellogg Foundation, the curriculum in all of our health professional schools is under change. Students, staff and faculty, and all of our University community will learn not only to live a healthy lifestyle, but to be prepared to serve the public through enhanced personal and professional knowledge in HPDP. We aspire to translate that knowledge to our friends and family and to others of the American public, including senior Americans. More recently other medical centers, including Michigan State University and the Eastern Virginia Medical Authority have initiated Wellness Programs.

10. The time has come for the Congress to assert its leadership role and to make an investment in HPDP. Your commitment must be strong, as it has long been in supporting biomedical research, if translation of available knowledge is to result in the prevention of disease and the accomplishment of health. I urge you to help those of us committed to HPDP establish Centers of Excellence in Wellness Education and Wellness Care.

Mr. Chairman, it is indeed a pleasure to testify before you and the members of your Committee in support of Health Promotion and Disease Prevention for all Americans and especially for our senior citizens.

Thank you.

Mr. Chairman and Members of the Committee:

I am Dr. James C. Hunt, Chancellor of the Center for the Health Sciences of the University of Tennessee and Professor of Medicine at the University of Tennessee College of Medicine in Memphis, Tennessee.

I wish first to thank you, Mr. Chairman, and members of the Committee for continuing the tradition of inviting citizens to testify directly to you in support of health programs which are in the public interest. As a practicing physician, medical school teacher, health sciences administrator, and for many years an active participant in the affairs of the National Heart, Lung and Blood Institute, I am especially grateful for this opportunity to ask your continued interest in improving the health of the American people through Health Promotion and Disease Prevention (HPDP).

Mr. Chairman, during my tenure as Professor and Chairman of the Department of Medicine of Mayo Clinic and Mayo Medical School, as President of the National Kidney Foundation, as Dean of the College of Medicine of the University of Tennessee, as a member of the National Heart, Lung and Blood Advisory Council, and, more recently, as Chancellor of the University of Tennessee Center for the Health Sciences, I have previously testified before several committees of the United States Senate and the United States House of Representatives concerning the importance of biomedical research and the need for the Congress of the United States to provide necessary funding for biomedical research and research training. On all occasions, I found the United States Congress to be responsive to the public need, and the National Institutes of Health and the National Science Foundation have received that necessary support to accomplish the nation's research mission. Indeed, much progress has been made over a period of the last four or five decades in accomplishing a better understanding of the mechanisms of disease and in effecting important new therapeutic approaches. Those of us long involved in patient care, health professional education, and biomedical research salute your strong commitment to the advancement of new knowledge in the cause, cure and prevention of disease in our nation.

Mr. Chairman, for many years I was privileged to live and work in the great State of Minnesota. It was my good fortune to develop a strong friendship with one of the members of your Committee. I ask personal privilege to acknowledge the many health services contributions of The Honorable David Durenberger of Minnesota. Senator Durenberger is a leader and he has demonstrated his commitment to the improvement of the health of the American people. I also request the privilege of publicly expressing my appreciation to a new friend and dedicated young Senator from the State of Tennessee who had a distinguished health affairs record during his years in the U. S. House of Representatives, The Honorable Albert Gore, Jr. Although not a member of this Committee, Senator Gore is clearly recognized in the State of Tennessee as a champion of HPDP.

Mr. Chairman, for many years, especially during and following World War II, there existed in this nation a significant shortage of health professionals which prevented appropriate access to health services for many of the American people. The Congress of the United States responded to this national need and the health professional colleges in the United States significantly expanded educational programs which were in a large part funded with public monies through the efforts of the Congress. There is no longer a shortage of professionals in most of the medical disciplines. Virtually all of our population may now achieve satisfactory access to illness care services. It is true that in some geographic areas, segments of our population, especially the elderly and the economically disadvantaged, are still underserved. However, the needs of these citizens could be fulfilled with better administration of available programs and services. It is my belief that this shortfall in services is in no way a result of inadequate support from the Congress and that these needs largely result from a failure to establish more adequate administrative supervision and application of available resources and manpower. The challenge is self evident and we must fulfill the illness care needs of all of our citizens.

The application of new biomedical scientific knowledge to the treatment of many of the dread diseases of mankind has resulted in improved survival, especially for persons with high blood pressure, infectious diseases and certain types of cancer. However, little has been accomplished in the prevention of disability and death for many persons with degenerative diseases. In certain areas, such as in diseases of the lung, the problem is rapidly becoming more severe. A notable exception is the favorable outcomes which have resulted largely from the Herculean effort of the National High Blood Pressure Education Program (NHBPEP). The NHBPEP has demonstrated the effectiveness of secondary prevention. I believe that all of us would agree that this is the model national program. In a large part, the NHBPEP is responsible for an almost thirty percent decrease in the heart attack death rate and an almost fifty percent decrease in the stroke death rate over the past decade. The Congress of the United States has strongly supported the NHBPEP which has functioned in the National Heart, Lung and Blood Institute and has enjoyed strong participation from a broad array of volunteer agencies, professional associations, the industry, and many concerned citizens. I have personally worked with the leadership of this program from the outset and it is my personal belief that this model program should be duplicated in many of the major disease areas which could benefit from this approach to accomplish HPDP.

Although some success has been accomplished in secondary prevention, especially in cardiovascular disease, the translation of biomedical scientific knowledge to primary prevention has left much to be desired, especially for older citizens. We have conquered polio and smallpox and can prevent most of the diseases of childhood. Yet, we have not appropriately applied current knowledge to the cure and prevention of many degenerative and self afflicted diseases of some young adults and most older Americans. Many of the health problems of adult Americans, especially those of the elderly, are in a large part a result of the lifestyle of our citizens. In short, we of the health professional community and the health service industry have not adequately concerned ourselves with prevention in the adult population. We continue to give dominant emphasis to illness care initiatives which certainly are of signal importance. However, most health professionals have not themselves been motivated to prevent disease and to maintain health. Health professionals function within a rewards systems which largely recognizes those accomplished in difficult feats of illness care. The macho image may have transferred from the brain surgeon to the heart surgeon and to the transplant surgeon or even, in part, to the biomedical scientist during recent years. After all, someone must design and build those marvelous artificial organs or discover new therapeutic agents. However, little adoration is afforded the architect of concepts and programs which inform the public, change behavior, prevent illness and improve health.

If illness care specialists can recognize and treat disease, do they not assure our good health? If physicians are good at illness care do they really need to learn about wellness and HPDP? Health professionals are paid for treating illness problems --- why should we as individuals pay good money to health advisors who mostly give us information not to our liking? We may not be physically fit and accomplished athletes, but are we not healthy? The patient care providers of the health serivce industry must accomplish a significant behavioral change if we are to achieve major HPDP goals and objectives. However, an even greater challenge is before us in that the American public has little understanding of the rudiments of HPDP and an even more profound change in the public attitude is essential if we are truly to change the basically unhealthy lifestyle of many citizens and assure good health for the American people.

During the past decade, a body of knowledge has been assimilated in wellness care disciplines and a growing number of persons desire health information. Many individual citizens are accomplishing a significant change in health behavior and are adapting to more healthy lifestyles. It is most encouraging to me that many younger Americans have demonstrated a strong motivation to effect improved nutrition habits and a healthy lifestyle. Yet, we in the Nation's Health Science Centers are only beginning our commitment to Wellness Care which is essential to any and all effective programs in HPDP.

Mr. Chairman, we at the University of Tennessee Center for the Health Sciences (UTCHS) are impressed as to the importance of Wellness Care. The vice chancellors, deans and departmental chairmen of the health professional schools are convinced that the health professionals of today and tomorrow should, and must, be equally concerned with Illness Care and Wellness Care. Wellness Care can be effective only through the application of biomedical scientific knowledge to HPDP. Our Colleges of Allied Health Sciences, Dentistry, Medicine, Nursing and Pharmacy, and the Graduate School of Medical Sciences at UTCHS have underway a campuswide conjoint effort to accomplish an equally significant commitment to the education of health professional students in Illness Care and in Wellness Care. The curriculum of all health professional students is already overburdened in the content area. We could not justify new contact hours in the curriculum. Thus, we have initiated a new approach to accommodate the Wellness Care educational needs of our students, staff and faculty. We have effected a University Health Service as a working laboratory for that effort. The University Health Service is the contact agency for any and all non emergent health services needs of the University family. Students, staff, faculty and dependents have immediate access to a health care team of nurses, dentists, pharmacists, physicians and allied health scientists expert in primary care and wellness care education. Direct access is assured to illness care specialists as necessary and needed. Health care team interaction is emphasized. A learning through personal involvement is assured.

It is difficult to add new initiatives in health professional education in public colleges and universities. It takes years to achieve new appropriated monies, consequently, we sought "seed monies" for our new initiative in Wellness Care Education from the W. K. Kellogg Foundation. The leadership of the Kellogg Foundation is committed to an enhanced personal experience in Wellness Education for all of our health professional students and has strongly endorsed this new approach to wellness education and health services. Through this new systems approach the students, staff, faculty and dependents of our University community will learn not only to live a healthy lifestyle, but also to better prepare themselves to serve the public through an enhanced personal and professional knowledge in HPDP. Through this experienced broader knowledge and stronger commitment in HPDP, hopefully we will translate our motivation to our friends and family and to others of the American public, including senior Americans.

The University Health Service at UTCHS is staffed by senior faculty members from the Colleges of Allied Health Sciences, Dentistry, Medicine, Nursing and Pharmacy. The environment is conducive to the team approach to Wellness Care Education. Health Science Administration students function side-by-side with health professionals in this environment. Health Services Research is conducted as an integral function of the University Health Service, and the appropriate function of various members of the health professional team is under study. We consider the University Health Service as a laboratory in which to determine health professional manpower needs, health service requirements, and new approaches to Wellness Care and Illness Care. We have dared to place our athletic facilities and cafeteria under the management of the University Health Service in order to emphasize the importance of physical fitness and nutrition as an integral part of an overall enchancement of Wellness Education. We promise to carefully monitor and to report this experiment to the scientific and professional communities.

The W. K. Kellogg Foundation, long recognized for its strong commitment to new approaches to health professional education and health services delivery, has invested almost two million dollars in this new approach to HPDP at UTCHS. Foundation leaders have counselled and assisted us in the design and evaluation methods for this endeavor. To date, we have experienced an overwhelmingly positive response and involvement from the University family. We believe we have at UTCHS the model for a Center of Excellence in Wellness Care and Wellness Education for health professionals and the public.

For more than twenty-five years, I have been personally involved in biomedical research and in HPDP at Mayo Clinic and at UTCHS. I have strongly encouraged that the Congress provide adequate funding for the nation's biomedical research effort. In my estimation, the time for support of a national effort in HPDP has arrived. It is in the nation's best interest that you establish Centers of Excellence in Wellness Care and Wellness Education. Through volunteer agencies and private philanthropy, a beginning has been made. The nation's Health Science Centers will respond to an investment from the American public if mandated by the Congress through the leadership of the Committee on Finance of the United States Senate.

Mr. Chairman, again, let me compliment you and the members of your Committee on your interest in the good health of the American people. My colleagues and I stand ready to be of any possible assistance to you as you continue to look at the important issue os Health Promotion and Disease Prevention for the American public, and especially for older Americans.

Thank you most sincerely.

THE UNIVERSITY OF TENNESSEE
Center for the Health Sciences
Office of the Chancellor

June 27, 1985

Shannon Salmon
Professional Staff Member
Committee on Finance
United States Senate
SD256
Washington, D.C. 20510

Dear Ms. Salmon:

On June 24, 1985, I received the enclosed letter from Edmund J. Mihalski requesting a follow up response concerning my testimony before Senator Durenberger on June 14, 1985. Senator Durenberger and the other members of the Committee on Finance are addressing extremely important issues and my associates and I wish to be of any possible assistance. My response to the question from Senator Packwood is appended. I thank you and Mr. Mihalski for the opportunity to respond.

Sincerely,

Jim Hunt

James C. Hunt, M.D.
Chancellor

jch:062785:sp

cc: The Honorable David F. Durenberger

62 South Dunlap • Memphis, Tennessee 38163 • (901) 528-5509

QUESTION FROM SENATOR PACKWOOD
CHAIRMAN, COMMITTEE ON FINANCE
UNITED STATES SENATE

Question: You have mentioned the favorable outcomes associated with the National High Blood Pressure Education Program (NHBPEP). In particular, you suggested that this program is responsible, in part, for an almost 30% decrease in the heart attack death rate and an almost 50% decrease in the stroke death rate over the past decade. My question concerns whether aspects of this model program can be replicated in other areas of health promotion and disease prevention? If so, in which areas and how would you apply the model?

Answer: More than twenty years ago, the American Heart Association and the National Heart Institute (NHI) recognized a national epidemic of coronary heart disease (CHD). High blood pressure (HBP), elevated blood cholesterol and other lipids (hyperlipidemia), cigarette smoking, sedentary activity and obesity were recognized as risk factors which potentially were subject to change. In the mid 1960's, the NHI sponsored the National Diet - Heart Feasibility Study to determine the feasibility of convincing free-living Americans to change their diet so as to lower their serum cholesterol. Feasibility was subsequently proved; however, a task force determined that a Diet Heart Study Intervention Clinical Trial would require the prohibitively costly participation of as many as one hundred million Americans to prove a statistically significant death rate reduction from lowering the blood cholesterol levels. More recently, the Lipid Research Clinic Reports and other interventions have proved the effectiveness of lowered blood cholesterol levels in reducing heart attack and CHD death rates. The evidence is conclusive that lifestyle is an exceedingly important factor in CHD and that an altered lifestyle through health promotion will decrease CHD deaths.

Because of the fact that HBP had for decades been recognized as the number one risk factor for heart attack, heart failure, stroke and kidney failure, an intensive nationwide public and professional educational program, the National High Blood Pressure Education Program (NHBPEP) was initiated through the leadership of the NHI in the early 1970's. At that time, less than 15% of persons with proved HBP were receiving treatment which restored normal blood pressure levels. Over the years this program has been under the leadership of the director of what is now the National Heart, Lung and Blood Institute (NHLBI), specifically Drs. Theodore Cooper, Robert I. Levy and Claude Lenfant at this time. The NHBPEP is guided by a coordinating committee of over thirty professional agencies and the HBP program network extends to 150 professional and voluntary societies, fifty state health departments and over 2,000 community programs. The last national probability survey (The National Health and Nutrition Examination Survey conducted 1976-80) reveals that 34% of Americans had their HBP under control and new, exciting data from the 1984-85 states' program reveal that almost 50% of those with HBP had their condition under control. The prevalence appears to be reduced, but more importantly, the mortality related to hypertensive kidney disease and hypertensive heart disease has been strikingly reduced over the past ten years and the death rate from stroke and from CHD have been reduced by almost 50% and 30%, respectively. A major behavioral change for health professionals and the public has clearly been proved. The NHBPEP, through the director of the NHLBI and the Coordinating Committee leadership, recognizes that much remains to be done; however, this program will continue to effectively lead the effort to reduce HBP related deaths. This program is the national model in secondary prevention. It is successful because of the involvement of many concerned expert persons and groups under a most dedicated leadership at NHLBI.

It has long been recognized that other risk factors, including hyperlipidemia, cigarette smoking, sedentary activity, obesity and substance abuse are also subject to modification through behavioral change. With established proof that reduction of blood lipid levels will result in decreased CHS deaths, the time has come to undertake a nationwide effort, similar to the NHBPEP, in the management of this risk factor. Further, the clear evidence that cigarette smoking deaths is on the rise and smokeless tobacco use, especially by our young people, is increasing makes it all the more imperative that a vigorous effort be made to address this risk factor through behavioral change. Many other causes of death and disability including lung disease, cancer, alcoholism, automobile accidents and others are profoundly influenced by the American lifestyle and are subject to behavioral change. However, such will not occur without active involvement of health professionals and strong central leadership.

As a participant in the NHBPEP since its outset, and as the current representative of the American Heart Association on the Coordinating Committee of the NHBPEP, I strongly urge that the Congress authorize, sponsor and fund through the National Institues of Health a conjoint effort under the leadership of the director of the NHLBI which should be known as the National Health Promotion and Disease Prevention Education Program (NHPDPEP). I believe that this program should be the successor to and should incorporate and expand those efforts currently undertaken by the NHBPEP. We have a seasoned, experienced and successful team in place. The current executive director of the NHBPEP, Dr. Edward Roccella, clearly has the capacity to serve a restructured coordinating committee, the sponsoring agencies and the American public in bringing out the changes necessary to accomplish the new and greatly expanded challenge. The Director of the NHLBI, currently Dr. Claude Lenfant, has demonstrated his leadership ability and, I believe, would assume the new and expanded responsibility. Finally, I suggest that the initial effort of the NHPDPEP be directed toward improving the diet of the American public and the cessation of cigarette smoking. Other interventions should follow.

I would be pleased to meet with Senator Packwood and Senator Durenberger, members of the staff of the Committee on Finance and others to define in a more specific fashion my recommendations concerning the establishment of a NHPDPEP as a major mission to accomplish risk factor reduction for heart disease, cancer and other dread problems which cause disability and premature death for the American public.

Thank you,

James C. Hunt, M.D.
Professor Medicine & Chancellor
University of Tennessee, Memphis

Senator **Durenberger**. Dr. Breslow, in your written statement you suggested that the Medicare Program cost of health monitoring, if it were patterned after the model which the private insurance industry is now exploring, would be considerably less than 5 percent of present Medicare expenditures. Are you referring to what is called the insure project? And would you elaborate a little bit on the model that you are suggesting to us?

Dr. **Breslow**. Yes, I am referring to the insure project, Mr. Chairman. I realize that you are going to be hearing directly from the insurance industry, but I am very pleased to answer that question as an advisory person to the project.

That program has now been underway for some 3 years in several communities throughout the United States. It provides payment by the insurance companies to physicians for a life-cycle model of preventive health services to people of all ages, including those beyond 65.

As I indicated in my remarks, the program is being well accepted. Furthermore, the preliminary evidence is that it is substantially effective.

A substantial part of the cost of the visit to the physician goes to pay for counseling services of the kind to which Dr. Kane referred, beyond payment for procedures. Such as blood tests. A package for a set cost is negotiated with a group of physicians.

For persons of all ages taken together, the cost has ranged from $75 to $80. For persons over 65, the cost of a particular visit is roughly $140. However, that service, the model provides, comes only to persons over 65 up to 74 once every 2 years; beyond age 75 every year. Furthermore, not every person who is eligible for that service does actually take it, even though encouraged to do so. So the programmatic costs would be far less than $100 per person.

Relating that to the cost of Medicare services, which are approximating $2,000 per person per year, it is evident that the cost of such preventive services would be substantially less than 5 percent of the total cost of Medicare services per person enrolled.

Senator **Durenberger**. All right.

Dr. Kane, would you give us some examples of what you call the "misinformation peddled by hucksters to the elderly" on prevention, and identify some of the health problems that might result from this peddling process?

Dr. **Kane**. The huckster is in, runs the gamut from things that are sold in the name of "health foods," to various kind of longevity diets that are being promulgated, to medicines—the most notorious of which is Gerovital, which is now being offered in the State of Nevada, with advertisements in surrounding States, inviting people to come for a weekend and have special treatment—to other kinds of activities which suggest that wearing certain kinds of equipment, or using certain kinds of equipment, will have a positive effect of health. Even calcium is being misused by older people, by selling expensive forms when cheaper ones are available.

I spend a fair amount of time counseling older people in senior centers about this kind of thing, and it is particularly bothersome to me that the poor elderly—the kinds of people you were making reference to earlier—are being victimized by such sales appeals. Elderly persons trying to do things positively for their own health, are in many cases are keeping the rats of our sewers well vitaminized with the excess vitamins that they simply don't need.

Senator **Durenberger**. And in each of those cases they are making an out-of-pocket commitment, are they not?

Dr. **Kane**. Absolutely. Out-of-pocket on a very limited budget, moreover.

Senator **Durenberger**. Yes. Right.

Could you give us some information on pneumococcal and pneumonia vaccine and also the influence of vaccines as to their efficacy? Only one of them is reimbursed under Medicare, and the other is not. Do you have a background and expertise that you could share with us on that?

Dr. **Kane**. I can give you secondary information; it is not an area of my primary expertise. I think, clearly, if one had to choose between them, the influenza vaccine administered to appropriate target groups is likely to be more cost-effective for the elderly than the pneumococcal vaccine. The advantage of the pneumococcal vaccine is that it is given once; the influenza vaccine has got to be given annually, according to the strain that is prevalent at the time.

Therefore, you are really talking about two different strategies for prevention—one, a more long-term strategy that would provide a more permanent protection for an older person; the other a strategy that is tempered by what is the prevalent strain on a year-to-year basis.

I think the cost-effectiveness of the two is certainly open to debate. Dr. McGinnis correctly alluded to some of the work that is currently going on. It is my understanding at the present time that no clear conclusion about the ultimate cost benefit are yet feasible.

Senator **Durenberger**. Jim, you talked in your statement about the wellness care education for students of the health professions. Is part of the reality that medical education today is just beginning to take into account health promotion, wellness, and so forth? Has it always been there but sort of neglected because none of the incentives, once they got out, seemed to work in the direction of wellness? Or what is the current state of wellness, health promotion and prevention, in the medical education system?

Dr. **Hunt**. It is really just beginning, Mr. Chairman, as you imply. But I think there is a growing interest and that the foundation is laid sufficiently well that we will see a major change, a rapid growth of that interest.

The American people are more interested in their health. The American people are more informed about health. We are seeing a change in terms of the appreciation of the need to have someone other than a pilot try to run the airline; there is a health care team concept developing. We are educating health professional students together; we are away from the concept that only the physician or the airline pilot can make that plane fly.

We demonstrated at Mayo with the Employee Health Service that the nurse could take care of 95 percent of members of our own families, and that they could work under algorithms with physicians.

One of my frustrations not only was the disincentive but the fact, by the time that a young dentist or physician or even nurse had completed their primary health professional education, they were almost impossible to educate in prevention. And this is why I felt I had to get into a university and start from day 1 with the dean or the chancellor hosting a lunch that was a hardy, healthy lunch for beginning medical and dental and nursing students. And believe me, it changes their behavior.

Senator DURENBERGER. But if you look at—well, you fellows probably have looked at it and I haven't—the prospective payment systems that we are designing, I don't see in them a lot of payoff for doctors spending time counseling people on this sort of thing, or having any other professionals in a group practice spending a lot of time doing that. I can see the incentives in a prepaid plan ought to be in that direction, and all of the things that Dr. Kane and I think all of you in your statements have alluded to—targeting the populations, and targeting certain kinds of services where they will do the most good.

But it strikes me that the reimbursement systems, the way we have put them up currently for Medicare, are designed only to remedy the problem, and it doesn't leave a lot of reimbursement in there for the time that necessarily must go into health maintenance.

Am I generally correct in that?

Dr. HUNT. Mr. Chairman, let me approach that question, because this week I had some very specific experience with Federal Express, which is one of the major employers in Memphis. Holiday Inn also has its national headquarters in Memphis, and Schering Plough has a major commitment in Memphis. I cite these three; there are others. Each of these industries has a very high illness-care cost schedule each year. Not only that, but they are on a long growth curve. Each of these major industries has undertaken not only an Executive Physical Program but an Employee Wellness Program, and we are working directly with them.

What they are doing is building an incentive system for their employees to reduce their health care costs through wellness education. This is not just fitness; this goes far beyond fitness. It is mental health, physical health, health education. And they are going to decrease their costs. Federal Express paid $30 million last year, and they have mostly young people—top pilots and a lot of young people who are running their delivery vans.

Industry and business—this is where the incentives are going to come initially, and this is where the prepayment will occur, not just in HMO's.

Dr. KANE. Mr. Chairman, I would just like to emphasize a couple of points. One, when we talk about the elderly, some of the things that apply in the organization of care to the younger population are much more complicated in older populations. There is a higher prevalence of chronic disease. Second, we are talking about a system of care which is financially fragmented from its very start. This separation tends to discourage investments in the acute care sector, for example, that could produce in the chronic care sector, but which is covered more by Medicaid than it is by Medicare. Thus we have different kinds of paradigms to think about when we look at the total potential for savings. We have created that monster by the way we have developed our funding system for the elderly.

We also have to recognize that physicians under Medicare, part B of which still pays a substantial proportion of physician bills, have no incentives for any kind of preventive activities; in fact they have a great many disincentives for this kind of activity.

Senator **Durenberger**. We keep freezing part B, the way we have done, there is no question about that.

Dr. **Kane**. What we want then is not simply to add another service that is paid for, but to take a larger step forward toward change in physician behavior, to create a climate in which physicians can do useful things. It doesn't have to be physicians, by the way.

Senator **Durenberger**. Right.

Dr. **Hunt**. I am glad to hear him change that a little bit.

Dr. **Kane**. But whoever is providing this kind of care should be offering organized primary care. What we have created under the current system of primary care in this country is really a very fragmented way of giving services. In its very essence, this fragmentation tends to create problems which can in fact be prevented.

We are looking for a larger reformation than simply adding another little piece of the system. The primary care contracting approach provides a way to identify and organize a primary care system which would come close to replicating what would be more available under a prepaid system is precisely what we are talking about.

Senator **Durenberger**. Les, do you have a windup comment on that, or would you like to comment on it?

Dr. **Breslow**. I would like to emphasize that industry is moving very rapidly into the provision of preventive health services of the kind we have been talking about here. It is the fastest-growing segment of health service in America. Industry is no longer willing to pay the higher and higher costs for increasing medical technology with extremely dubious health benefits. In preventive services they find that they are really accomplishing something.

The health insurance industry, as I have indicated and by your question expanded on already, is also moving in that direction. And they are showing that it is possible to do the same for people over 65.

We have reached the time when it is up to the Federal Government, in its responsibility for Medicare, to provide that same kind of benefit to persons over 65. For their remaining years, preventive services will be of help to those over 65, as they are to younger people.

Dr. **Hunt**. If the chairman is going to be a role model in not smoking, it is time that all health professionals be role models for wellness.

Senator **Durenberger**. Thank you all very much. I appreciate your comments and your testimony.

Our next panel is Dr. Donald Vickery, president of the Center for Corporate Health Promotion, Reston, VA, on behalf of the American College of Preventive Medicine; and Dr. William Bridgers, dean of the School of Public Health at the University of Alabama, on behalf of the Association of Schools of Public Health.

Jim, before I forget, I wanted to mention to you that Al Gore tried to get here this morning and got waylaid someplace. So that is for the record.

Dr. Vickery, welcome. I guess you know that both of your statements are excellent—you knew that before you came. They will be made part of the record, and you may summarize them in 5 minutes.

Dr. VICKERY. Thank you.

STATEMENT BY DONALD M. VICKERY, M.D., PRESIDENT, THE CENTER FOR CORPORATE HEALTH PROMOTION, INC., RESTON, VA, ON BEHALF OF THE AMERICAN COLLEGE OF PREVENTIVE MEDICINE, WASHINGTON, DC

Dr. VICKERY. Mr. Chairman, health promotion for Medicare beneficiaries constitutes the greatest opportunity for the Congress to improve the health of the elderly by helping to contain medical care costs. We strongly support your efforts in this regard and are anxious to assist in this most important endeavor.

The public's image of aging is clear—the elderly are "weak, frail, slow, sick, confused, tired, and lonely." But this clear image does not service well; in fact, the effects commonly ascribed to aging are in reality due to three separate processes:

First, "disuse disease" is a term we use to indicate that loss of function resulting from simple failure to use physical and mental faculties. In considering the disability caused by disuse we see that "use it or lose it" is not just a slogan but a principle of human biology.

Second, chronic disease related to risk factors, many of which are heavily influenced by lifestyle.

And finally, cellular aging—those changes in cellular function that are in fact inevitable with the passage of time.

The promise of health promotion for the elderly is clear. By modifying what Americans do to and for themselves, we may markedly diminish the impact of chronic disease and disuse disease. Sick and dependent old age is not inevitable, and most Americans may achieve an ancient goal—to live a long time and die young.

We believe that the Nation can no longer afford to ignore the health-promotion option—health promotion, including appropriate self-care and self-help activities is the only approach that offers improved health and decreased medical care costs.

In considering the state of the art of health promotion, some may question as to whether or not an elderly population that adopts healthier lifestyles will in fact benefit. Professor Breslow's testimony addresses this question eloquently and persuasively. The more difficult issue is whether or not there are effective methods by which older Americans may be influenced to adopt a healthier lifestyle.

The search in this area has not been a high priority, and the data available are far less complete than we would like; nonetheless, I am confident that a prudent individual will conclude that the evidence for efficacy of health promotion is compelling.

I would suggest the following for your consideration:

First, immunization and screening are important, but the greatest potential is in the area of lifestyle.

Second, most lifestyle is self-change; medical therapy is not a prerequisite for change. The work of Brownell, McAbee and others suggests that the assertion that the promotion of self-change is the critical task, and that communications and methodologies may be the most appropriate for this task.

Third, the elderly are not exceptions to the health-promotion rule. To be sure, they require programs appropriate for their interests and capabilities; but they are not set in their ways and unable to respond. For example, studies suggest that persons over the age of 65 who engage in appropriate physical training may retain 85 percent or more of the physical capacity that they exhibited as college students. The cooperative health education project found that Medicare beneficiaries reduced doctor visits by 15 percent in response to a health promotion program, which is very similar to the decrease found for persons under 65. Most intriguingly, results from the Seattle longitudinal study suggest that the elderly may in fact be able to improve their intellectual capacities through mental training.

Fourth, different approaches can and have been found to be effective. This leads to the current challenge with respect to health promotion and Medicare.

How should health promotion for the elderly be done? The history of corporate health promotion may be instructive in this regard. Corporate health promotion programs have used screening and physical examinations, fitness facilities, and professional staffs, as well as behavior modification groups. But the cutting edge of corporate health promotion today is communications technology. Nevertheless, despite the impressive cost effectiveness of communications programs, there are effective programs which use screening facilities and behavior modification groups.

It should also be noted that corporate health promotion programs are not dominated by any one professional group. Communicators, health educators, exercise physiologists, physicians, nurses, and others have all participated in the development and implementation of effective programs.

The challenge, then, is not to identify a single program as the model for the Medicare Program, but rather to get on with the bringing of the benefits of health promotion to Medicare beneficiaries.

As a representative of physicians whose special interest is health promotion and disease prevention, the college is anxious to assist in this process.

Mr. Chairman, it is said where there is a will there is a way. When it comes to health promotion and Medicare, there is not only a way but several ways. What older Americans need is an expression of will from the Congress.

Thank you.

Senator **Durenberger**. Thank you very much.

Dr. Bridgers.

[Dr. Vickery's written testimony follows:]

THE
AMERICAN
COLLEGE
OF
PREVENTIVE
MEDICINE

PROVIDING LEADERSHIP IN HEALTH PROMOTION AND DISEASE PREVENTION

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Statement of

Donald M. Vickery, M.D.

President, The Center for Corporate Health Promotion, Inc.
Reston, Virginia

and

Fellow of the
American College of Preventive Medicine

before the

Committee on Finance
Sub-Committee on Health
U.S. Senate

"Health Promotion and Disease Prevention
Strategies for Medicare Beneficiaries"

Dr. Vickery is presenting this testimony on behalf of the American College of Preventive Medicine.

Founded in 1954, the American College of Preventive Medicine is a scientific society of physicians engaged in practice, teaching and research in preventive medicine. Committed to promoting the health of the individual, the community and the nation, the College's goals focus on advancing the science and art of health promotion and disease prevention.

ACPM's membership is composed of 2,200 physicians, primarily board-certified in one or more of the four preventive medicine disciplines: public health, occupational medicine, general preventive medicine, aerospace medicine. College members occupy key posiions in government, industry and academia. Many are clinicians providing direct patient care in the workplace, community clinics, health centers and private offices. The College constitutes a major national resource of expertise in areas vital to protecting and improving the nation's health, and provides guidance and direction to policymakers, planners, practicing physicians, other health professionals and the public on health promotion and disease prevention issues.

Donald M. Vickery, M.D.
Testimony before the Subcommittee on Health, Senate Finance Committee
June 14, 1985

Mr. Chairman, health promotion for Medicare beneficiaries constitutes the greatest opportunity for the Congress to improve the health of the elderly while helping to contain medical care costs. We strongly support your efforts in this regard and are anxious to assist in this most important endeavor.

The public's image of aging is clear. The elderly are weak, frail, slow, sick, confused, tired, lonely. But this clear image does not serve us well. In accepting it, we accept the myth that these effects are an inevitable part of aging. In fact, the effects commonly ascribed to aging are in reality due to three separate processes:

1. Disuse Disease

These are changes in body functions resulting from failure to use physical and mental faculties. We have used this term to indicate loss of function resulting from failure to use physical and mental faculties. In considering the disability caused by disuse, we see that "use it or lose it" is not a slogan, but a principle of human biology.

2. Chronic Disease

The most prevalent of these diseases are arthritis, diabetes, cardiovascular disease and chronic obstructive lung disease. These diseases are related to risk factors which are influenced heavily by lifestyle. There is substantial evidence that modification of lifestyle modifies the risk of these diseases.

3. Cellular Aging

This is the "real" aging, i.e., those changes in cellular functions that are inevitable with the passage of time. Current knowledge does not allow us to determine how this process might be modified in humans.

In this context, the promise of health promotion for the elderly is clear: By modifying what older Americans do for and to themselves, we may markedly diminish the impact of chronic disease and disuse disease. A dysfunctional and dependent old age is not inevitable, and most Americans may achieve an ancient goal: To live a long time and die young.

We believe that the nation can no longer afford to ignore the health promotion option. Cost savings, as opposed to cost shifting, can be achieved in only three ways: 1) health may be improved so that fewer services are needed; 2) the use of medical care services may be made more appropriate; and 3) the cost of services may be decreased. Cost containment efforts to date have focused on the third approach. But this approach runs the risk of denying needed medical services and increasing cost in the long run. Further, apparent cost savings may in fact be cost shifting upon closer analysis. Health promotion, including appropriate self-care and self-help strategies, avoids these difficulties.

Health Promotion: The State-of-the-Art

Some may question as to whether or not an elderly population that adopts healthier lifestyles as well as appropriate immunization and screening practices will in fact enjoy lower morbidity and mortality. Professor Breslow's testimony addresses this question eloquently and I feel certain that any reasonable doubts in this regard can be satisfied.

A more difficult issue is whether or not there are effective methods by which older Americans may be influenced to adopt healthier lifestyles, as well as undergo appropriate immunizations and screening procedures. Research in this area has not been a high priority for either public or private funding sources and the data available are far less complete than we would like. Nonetheless, I am confident that a prudent individual will conclude that the evidence for efficacy in health promotion is sufficient. Based on the available information and personal experience over the last decade, I would suggest the following for your careful consideration:

1. Immunization and Screening are important, but the greatest potential for health promotion is in the area of lifestyle. This is especially true when looking at the outcomes of lowered morbidity and improved productivity.

2. Most lifestyle change is self-change. Therapy is not a prerequesite for change. For example, over 95% of the approximately 35 million Americans who stopped smoking since 1963 have done so without attending a smoking cessation group, seeing a physician, being hypnotized, using nicotine gum or in any other way undergoing therapy. The work of Brownell and others supports the assertion that the promotion of self-change is the critical task for the most cost-effective health promotion programs. Communications methodologies may be most appropriate for approaching this task as indicated by the success of the Stanford Heart Disease Prevention Program, the North Karelia Project, the Minnesota Heart Study, the Pawtucket Study and other programs that have made extensive use of communications.

3. The elderly are not exceptions to the health promotion rule. To be sure, they require programs appropriate for their interest and capabilities, but they are not "set in their ways" and unable to respond. For example, studies with regard to physical training in the elderly suggest that persons over the age of 65 who engage in appropriate physical training may retain 85% or more of the physical capacity they exhibited as college students. The Cooperative Health Education Project found that Medicare beneficiaries reduced doctor visits by 15% in response to a health promotion program. A similar program used with individuals under the age of 65 resulted in a 17% decrease in doctor visits, essentially the same decrease. Most intriguingly, results from the Seattle Longitudinal Study suggest that the elderly may in fact be

able to improve their intellectual capacities through mental training.

4. Different approaches can be effective. This leads to the current challenge with respect to health promotion and Medicare.

Health Promotion: The Challenge

How should health promotion for the elderly be done? The history of corporate health promotion may be instructive in this regard.

Following World War II, the earliest health promotion programs concentrated on screening and physical examinations to detect asymptomatic illnesses. Enthusiasm for this approach declined, a few companies invested in fitness facilities and professional staffs run them. However, the cost involved and disappointing participation rates limited the utility of this approach. The emphasis currently is on behavior modification groups, smoking cessation courses, weight control groups, etc. - but these also have some problems with respect to cost and participation. As a result, the cutting edge of corporate health promotion is now communications designed specifically to influence health behavior. Despite the impressive cost effectiveness of state-of-the-art communications programs, there are effective programs in the areas of screening, facilities and behavior modification groups. Indeed, the most impressive programs have elements from all of these areas.

It should also be noted that corporate health promotion programs are not dominated by any one professional group. Communicators, health educators, exercise physiologists, physicians, nurses and others have all participated in the development and implementation of effective programs.

The challenge, then, is not to identify a single program as the model for the Medicare program, but rather to get on with bringing the benefits of health promotion to Medicare beneficiaries. This will require taking advantage of what we already know and gaining experience with the Medicare populations specifically. As a representative of those whose special interest is health promotion and disease prevention, the College is anxious to assist in this process.

It is said that where there is a will, there is a way. When it comes to health promotion and Medicare, there is not only a way but several ways. What Older Americans need is expression of will from the Congress.

Thank you.

STATEMENT BY WILLIAM BRIDGERS, M.D., DEAN, SCHOOL OF PUBLIC HEALTH, UNIVERSITY OF ALABAMA, BIRMINGHAM, AL, ON BEHALF OF THE ASSOCIATION OF SCHOOLS OF PUBLIC HEALTH, WASHINGTON, DC

Dr. **Bridgers**. Thank you, Mr. Chairman.

Those of us in schools of public health are very grateful for the opportunity to testify on behalf of S. 359, and we thank you for your efforts to recognize the concepts of health promotion and disease prevention as valid strategies for assuring healthy lives for all of our citizens.

The original purpose of Medicare was to pay for needed health care for the elderly; however, ignored until now has been the need for preventive services. Others at this hearing have testified as to the significant health benefits of these services, and I will, therefore, take a slightly different focus in my few minutes.

Medicare is concerned with the escalation of costs, and lowering this burden has been an overriding interest of the last few years. Until now, the potential of prevention for lowering the burden of illness which created the burden of cost has been overlooked.

There are really only a couple of ways to reduce health care costs. One is to reduce the prices of needed treatments through regulatory or other competitive strategies, and the other is to reduce the number of such episodes that are required.

Very little attention has been directed toward the possibility of reducing episodes of illness through prevention. Medicare pays for treatment of most acute exacerbations of chronic disease, but it does not as yet pay for the inexpensive preventive efforts that might reduce the numbers of such episodes—with the sole exception, presently, of the pneumococcal vaccine.

The historic focus of Medicare upon acute episodes of illness is a reflection of the state of knowledge of health and disease at the time the legislation was enacted. But the knowledge base of human biology and the causes of disease has undergone an explosive increase since then.

John Maier said recently, "Every generation redesigns what is intolerable in public health as science generates the knowledge needed for action." Although this was said in a different context, it is germane to our discussion today. It is timely for Medicare to incorporate new provisions based on new knowledge.

The question then becomes: Is there evidence or experience to support the contention that prevention programs could cut outlays?

Well, rigorous research studies have been minimal due to lack of funds and trained investigators. However, there are reasons to believe that prevention programs could reduce the incidences of some chronic diseases and their acute exacerbations. For example, there is little doubt that the sharp decline in cerebrovascular mortality—that is, strokes—is related to the fact that today many more people with high blood pressure are aware of their condition and are maintaining their blood pressures within safer ranges.

In the interest of time, I will note only another example of the potential of cost effectiveness of preventive health care.

The Center for Disease Control has continually noted the cost effectiveness of immunization programs—for example, for measles, polio, and many other diseases including influenza. And this is especially germane to the elderly and to those with cardiopulmonary disease. I believe we might find that Medicare reimbursement for selective immunizations might be added to the list of reimburseables, and hence encourage services.

Mr. Chairman, historically, preventive interventions have always had to meet a test not usually applied to therapeutic measures. Preventive measures must be shown, before the fact, to be both beneficial and cost effective. The demonstrations proposed under this bill are aimed at making a financial case for prevention as well as the health-benefits case, and in a convincing manner, if at all possible. Thank you.

[Dr. Bridger's written testimony follows:]

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STATEMENT OF

WILLIAM F. BRIDGERS, M.D.

DEAN, SCHOOL OF PUBLIC HEALTH

UNIVERSITY OF ALABAMA AT BIRMINGHAM

AND

PRESIDENT OF THE

ASSOCIATION OF SCHOOLS OF PUBLIC HEALTH

BEFORE THE

COMMITTEE ON FINANCE

SUBCOMMITTEE ON HEALTH

U.S. SENATE

S.359

"TO PROVIDE MEDICAL DEMONSTRATIONS
IN HEALTH PROMOTION AND DISEASE PREVENTION"

June 14, 1985

Washington, D.C.

Mr. Chairman, I am Dr. William Bridgers, Dean of the School of Public Health at the University of Alabama at Birmingham and President of the Association of Schools of Public Health, on whose behalf I am appearing today. We appreciate the opportunity to testify on behalf of S.359, your bill to provide demonstrations to reduce disability and dependency through the provision of prevention services to Medicare beneficiaries. We strongly support it and applaud your efforts to recognize the concept of health promotion and disease prevention as an effective way to control skyrocketing medical care costs.

As you know, the purpose of this bill is to test the feasibility of Medicare reimbursement for preventive health services.

Mr. Chairman, we are all well aware that the purpose of Medicare is to pay for needed care for the elderly and some other beneficiaries. It is first and foremost a financial mechanism. Its purpose is not to advocate or advance preventive health care, but to pay for whatever health care is needed by its constituents. Like all health insurance institutions (whether for-profit or non-profit), it is concerned with the question of cost, and lowering its cost burden is a primary interest. Therefore, it is the cost-effectiveness of prevention that I will address today, not its health benefits.

There are basically three ways to cut or contain health care costs. One is to reduce the price of treatment. The second is to reduce [or eliminate] the number of treatment episodes, and the third is to lessen the severity of the treatment needed (e.g., medication or minor surgery vs. major surgery). Most cost containment efforts have focused on reducing treatment costs. Little attention has been directed toward the other two options. This is a particularly serious problem for Medicare because its beneficiaries are a population consisting predominantly of individuals with actual or potential chronic health care problems. Medicare pays for treatment of most acute exacerbations of chronic disease, including a heavy outlay for terminal episodes, but it does not pay for the preventive efforts that might reduce the number of acute episodes (with the sole exception of pneumococcal vaccine) or for measures which now show promise to reduce the actual prevalance of chronic diseases in the aging population.

The focus of Medicare upon acute episodes of illness is a reflection of the state of knowledge of health and disease at the time the Medicare legislation was enacted in 1965. Little was understood about causes of the major chronic diseases; little benefit from comprehensive, ongoing maintenance was seen; and virtually nothing was known about preventive measures. But the knowledge base of human biology and disease has undergone an explosive increase since then, and it is timely for the Medicare system to incorporate new provisions based on this new knowledge.

The question then becomes, is there evidence or experience to support the contention that prevention programs would cut Medicare outlays for therapeutic care? Rigorous research studies have been minimal due to lack of funds and trained investigators. However, there is considerable evidence that prevention programs and preventive care can reduce the incidence of chronic diseases, and, therefore, costs. For example, there is little doubt that the sharp decline in cerebrovascular mortality is related to the fact that today most people with high blood pressure are aware of their condition and are under treatment.

Mr. Chairman, I would like to use two examples of the potential costs benefits of preventive health care for the elderly. One concerns primary prevention (the prevention of disease) and the second concerns secondary prevention (early detection and treatment).

The highest incidence of tetanus in the United States occurs among the elderly, over half of whom do not have sufficient serum level protection. Mortality from tetanus among the elderly is as high as 80 percent, yet tetanus is easily prevented by immunization. The Centers for Disease Control has continually noted the cost-effectiveness of immunization programs for measles, polio and influenza. Influenza immunization has been especially effective for the elderly and persons with cardiopulmonary disease. I believe we would find that Medicare reimbursement for tetanus immunization would also be highly cost-effective.

The second example I would like to mention involves the early detection and treatment of breast cancer. Fifty percent of all breast cancers occur in women over the age of 65, and both incidence and mortality increase with advancing age. However, the survival rate for older women who are treated is as good as it is for young women, and recent studies have shown that screening programs are most effective among elderly women. Despite this good news, sixty percent of women over the age of 75 are not receiving annual breast examinations and two-thirds of women over age 65 have not been instructed in breast self-examination. Considering the enormous costs of therapeutic or terminal episodes which are the inevitable consequence of undetected cancer, screening and health education programs would appear to be very cost-effective.

There are a number of other examples of simple, inexpensive procedures that could prevent or reduce serious illness and disability--glaucoma screening, hypertension screening, and screening for colon cancer are a few examples.

Mr. Chairman, it is unfortunate that preventive interventions have always had to meet a test not applied to therapeutic measures. Preventive measures must be shown before the fact to be both beneficial and cost-effective. This is a standard that is not applied to treatment--indeed, Medicare does not allow cost considerations for new therapeutic procedures. Yet the question of cost is always raised when prevention is mentioned. The demonstrations proposed under this bill are aimed at making the financial case for prevention in a convincing manner.

Mr. Chairman and members of the committee, we urge you to adopt S.359 as written and applaud your foresight in holding hearings on a bill that emphasizes disease prevention and health promotion among the elderly. The bill will not only help to save lives and improve the quality of life, but will also save money in the foreseeable future. We thank the members for giving us the opportunity to comment and support this prevention bill. We are most willing to work with you and with your staff in seeking enactment of S.359. Thank you.

I will be honored to answer any questions.

Sources:

Stults, Barry M. "Preventive Health Care for the Elderly." The Western Journal of Medicine, December, 1984.

Somers, Anne R. "Why Not Try Preventing Illness as a Way of Controlling Medicare Costs?" The New England Journal of Medicine, September, 1984.

ASPH
ASSOCIATION OF
SCHOOLS OF
PUBLIC HEALTH

July 8, 1985

United States Senate
Committee on Finance
Washington, D.C. 20510
ATTN: Ms. Shannon Salmon

Dear Ms. Salmon:

As a follow-up to my recent June 14 testimony before Senator Durenberger, Mr. Mihalski requested that I respond to a question, attached. I am pleased to submit the following.

Sincerely,

William F. Bridgers, M.D.
President, Association of Schools
of Public Health

Dean, School of Public Health
University of Alabama at Birmingham

WFB/cjj
attachment
cc: Mr. Michael K. Gemmell
Executive Director, ASPH

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Question For Dr. Bridgers

1. The kind of demonstration I have proposed in S. 359, will provide important knowledge and data on the short and long-term costs and benefits of preventive services for Medicare beneficiaries who received care under the program. It is, therefore, critical that these programs be properly evaluated. What evaluative measures would you propose in this regard?

Dr. Bridgers - Mr. Chairman, I agree that careful evaluation of the demonstrations proposed in S.359 would be essential. It will, however, be difficult to manage, just as evaluative procedures frequently prove to be. In the case of S.359, one of the "bottom line" measures should be the impact of simple preventive measures on the rates of acute exacerbations of chronic condition. It is these acute episodes that presently generate much of the Medicare outlays.

In order to properly evaluate such programs, it would be desirable to develop an experimental design which allows interested Medicare participants to be randomly assigned to two different groups: one group which will have the full spectrum of interventions available, and another which will receive usual and customary Medicare services. Rates of hospital care, costs of preventive and therapeutic interventions, and patient compliance and satisfaction could all be measured in the two groups, over time.

To facilitate rapid acquisition of reliable information, it would be helpful to form a coalition of the five projects under the overall supervision of a team of researchers at one of the participating schools of public health. This would expand discussion between the five sites and make possible the development of some commonly shared data collection procedures. In that way, the five separate projects could function, to some extent, as one large project and produce more, and more reliable, data quicker than would otherwise be possible.

Measurement of the impact of these projects upon health and costs will take a considerable amount of time. In the short term of three years, only information about the different mechanisms of providing the services can probably be demonstrated. This, however, is a most important beginning. It will take a few more years to be able to demonstrate the health status benefits which we believe will ensue and perhaps even longer to measure changes in the costs of savings of Medicare services unequivocally attributable to the interventions. Nevertheless, it is certainly time and timely to commence the effort.

Senator DURENBERGER. Thank you very much.

One of the things that is apparent is the lack of what people would call "hard data" on cost effectiveness of preventive care for anybody, and particularly for the elderly. Yet it seems so obvious. It's one of those things that is so obvious that it is cost effective, yet nobody seems to have any information on it.

First, is that true? Second, is it because it is difficult to measure? Third, is it because we haven't concentrated on the issue and therefore we don't have 5 years, 10 years, 20 years of data?

After you react to that, what can we do about this problem of lack of hard or adequate data? Can each of you respond to that in some way?

Dr. BRIDGERS. I will take a stab at it. I think most people intuitively agree with Ben Franklin's old adage that an ounce of prevention is worth a pound of cure. I think if Franklin were rephrasing that in the language of today he might say something to the effect that an ounce of prevention is cost effective. But again, the evidence for it in terms of rigorously controlled studies really isn't available in great depth, largely because no one has devoted the attention to the issue yet that is required.

It is a catch-22. If a preventive service has to be considered to be proven to be cost effective before it is introduced into the armamentarium of the physician, and yet you can't do that until you introduce the service and study its affect, then you are really in a catch-22 situation.

I think a new approach to looking at the question of the cost effectiveness of prevention versus treatment is to consider that the cost of prevention is the cost of the prevention alone, the only cost connected with that process. The cost of treatment, though, has some hidden costs that we haven't thought enough about how to measure yet; specifically, the cost of treatment of a disease after the fact requires a measure of the cost of the diagnosis, which can now be quite expensive, the cost of the treatment, whatever it might be, and then the largest cost perhaps of all is the cost of dependency related to that illness or that injury. These have not been measured carefully. We know they are there and that they last many, many years. Then they greatly exceed the cost of even the treatment or the diagnosis.

It is studies along those lines that I think might someday give us that firm bottomline that we would all very much like to have.

Dr. Vickery; I would slightly disagree, in the sense that there are some studies. I have mentioned the cooperative health education project which demonstrated savings of $3 in terms of omitted doctor visits for every dollar spent on the program intervention. There are others. Kelly Brownell's studies was a cost-benefit study which demonstrated that his methodology, which was unique and intriguing, resulted in cost effectiveness.

There is not a great deal of it, because it has not been a priority for either public or private funding sources. Clearly, that is one of the things we need to change.

But if I may draw on my experience with the corporations of this country and their interest in health promotion, they started at this very point about 10 years ago, perhaps, on average, and asked the very same questions of, "Show me the data where I will save money." Over time they have become convinced that a prudent man would not decide against health promotion, that while the studies to date cannot provide five well-controlled studies on a company just like theirs that demonstrates they cannot lose money, they have decided that a prudent manager would be foolish not to take health promotion seriously.

So I think we would certainly applaud the appropriation of further sources both private and public toward the research questions involved; I really think it has moved beyond that and is a question of more practicalities.

The bottom line, the proverbial bottom line, with respect to business, is very real, and they don't violate that.

Senator **Durenberger**. I don't want to take a lot of time expanding on this view, and maybe you can add to it and other witnesses can, too, in your additions to the testimony, but do either of you have a view on the kinds of incentives that work best with today's elderly population? As I view today's elderly population, they are relatively well off compared to their parents in retirement, so to speak, and yet they are the adult victims of the Depression, and they live—even though they may be so-called well off—they live in fear of catastrophe, and so forth. So they are very susceptible to bargains and to deals and to that sort of thing. They gobble up all the hucksters, as we heard from a previous witness. You can just see it on television. Every movie actor, when they reach 65 years of age, signs on with some insurance company to sell something to the elderly, and it is all sold on the "protection" theory.

Do you know of ways that are particularly applicable to this generation, my parents' generation, in effect, of what somebody yesterday called "the chronologically gifted"—a new word, think about that—that would get them or cause them to change their health habits?

Dr. **Vickery**. I think one of the remarkable things that we have experienced in our research is the great advantage that we have in doing health promotion with the elderly. As you have mentioned, their two great interests are in protection for their health and protection for their financial status. In a sense, that is a great advantage. They come interested in health; whereas if we were talking about a group of teenagers, we might not have that advantage. We found that while one must always pay careful attention to motivation, and the use of incentives can be a very important part of that, in general that is not a problem. Furthermore, we have been somewhat amazed that techniques that we have used with persons in other age groups—that is, the provision of information and the use of communications techniques that works with younger groups—also works with the elderly. So in that sense, we have a better chance, and we have seen the other side of the coin. We have seen the willingness to buy into less than ethical and certainly poorer approaches to trying to preserve health, rather than the easy purchase, if you will, of appropriate means of preserving health.

Senator DURENBERGER. Gentlemen, I thank you very much for your testimony, and I take it you will be hearing from us more in the future.

Thank you.

Our next witness is Paul Barnhart, who is the chairman of the Committee on Health for the American Academy of Actuaries.

Paul, thank you very much for giving us your time today. Your testimony in full will be made part of the record, and we welcome your summary of that.

STATEMENT BY PAUL BARNHART, CHAIRMAN, COMMITTEE ON HEALTH, AMERICAN ACADEMY OF ACTUARIES, WASHINGTON, DC

Mr. BARNHART. Thank you, Mr. Chairman, and on behalf of the academy I would like to express our appreciation for the invitation and the privilege of being able to testify at your hearing this morning.

The role of the American Academy of Actuaries is not to take a position on any public policy; instead, we see our role as providing objective information and actuarial analysis that we hope will be of help to decisionmakers such as your subcommittee and others in Government. We are always available to try to provide as much information and actuarial evaluation as we can, but to do so without taking any specific position on a matter of public policy.

As you mentioned, Mr. Chairman, I am the chairman of the Academy's Committee on Health—which may be another misnomer, a little as you had characterized the name of your subcommittee. It used to be called "the Committee on Health Insurance." And in an effort to emphasize that we need to have a broader view and a broader role, we changed the name to "the Committee on Health."

In my verbal summary, I want to concentrate on some of the items described in section 2 of my written statement, which deals with a number of actual experiments that have been conducted at one time or another under insured plans. And these mostly have fallen into five areas.

One of them has been the extension of coverage to preventive care expenses, in some way or other, the simplest example being extending coverage to annual physical checkups under a health insurance program.

Devices of this kind have led to rather inconclusive results. Much of the time they seemed to have simply increased the cost of the plan without any discernible beneficial results. I think this may in part be due to the fact that often these features were not promoted or emphasized very strongly. They were there, but I suspect that many of the enrolled individuals simply may not have been aware that certain types of preventive care were covered under the plan. But whatever the reason, the general experience has been a little inconclusive. We have seen increases in cost under such plans and for the most part have had difficulty in discerning real health beneficial results as the result of a lot of these experiments.

The second area where experiments have been conducted on a quite wide scale for a number of years is to provide cash refunds, or a return of some portion of the premium, to individuals who have not had claims. These programs, for the most part, have led to quite distinct reductions in cost—they seem to have been cost effective, in the sense that the benefits paid out under many of these kinds of programs have reduced, as a result of this.

The problem has been whether health has really been promoted, or whether the covered individuals have simply not submitted claims, or perhaps have not sought medical care, even when they should have done so, simply in order to qualify for the refund, the cash refund or the return of premium. So under these programs also, while cost has been reduced, there remains a question as to just how effective they have been in really promoting better health.

Another area, the third general area I wanted to refer to, has been the introduction of preferred-risk discounts in many areas with regard to premiums. The best-known of these is the nonsmoker discount. It has become very prevalent in life insurance, very widely used by insurance carriers, and it is being used with increasing frequency in disability income insurance. It has been done long enough in life insurance that quite a bit of data has begun to emerge, and the life insurance carriers have quite a bit of information about the results of nonsmoking with regard to mortality. In disability income it is so far new enough that there is very little by way of data available as to what the effectiveness of this has been.

A fourth area is in renewal premium reclassification. I just want to mention here that there is a new program underway in the State of Illinois. I have had the privilege of working with that myself as a consultant, where the members are entitled to qualify for various kinds of renewal premium reclassification, either because of no claims or because of submitting evidence of discontinuing the use of smoking, or entering into a weight-control program—various things that qualify them for renewal premium discounts. And on the other side of it, there are also renewal premium surcharges for those whose experience has gone the other way.

My time is up. May I just quickly mention the other one or two points?

Senator DURENBERGER. All right. Have you mentioned the total care programs?

Mr. BARNHART. Yes. Just one further quick comment on this Illinois program—this is a new program. It was instituted January 1 of this year, and I am meeting next week with the insurance committee of the program to have our first review session. We are going to monitor this program very closely. This is a large Illinois association. It has about 140,000 subscribers and their dependents, and we are going to be monitoring the results of this program very closely.

Senator **Durenberger**. Well, the heart of what I would like you to get at for us is, I think, C&D. The others obviously have value, but how is C different from D? In other words, how is the preferred risk different from the various classifications or the reclassification on renewal?

Mr. **Barnhart**. All right. The preferred risk discount programs are done at the time of issue; in other words, when the applicants are processed by the insurance carrier. And they will be placed into a particular premium classification at the time the policy is issued. Thereafter, they remain, as a rule, in that classification; although, sometimes there are provisions made that they can submit renewed evidence at a later time and perhaps get into a more favorable premium classification. But this device is used at the time of underwriting, at the time the individual applies for coverage.

The other one, that is being followed by the Illinois Health Improvement Association, is an ongoing program applied yearly to all of the enrolled members. Every one of them is subject to the possibility of reclassification.

Senator **Durenberger**. But I still don't see the difference. In most of these insurance plans whenever our so-called premiums come up, usually a 12-month period of time, we have an option of going to another company, another plan, or renewing the old plan. So what difference does it make whether we are making a decision on a preferred-risk plan or a premium-reclassification plan?

Mr. **Barnhart**. Well, on the reclassification plan it is done right within the program, and one of the objectives that we hope to realize is to maintain the health of the group as a whole; in other words, to maintain a better quality of enrollment. We expect to see fewer people leave the plan, for example, and go out and seek other insurance. So part of the objective is to keep them in the program and maintain the group itself as a healthy group.

Senator **Durenberger**. OK. And that's why, as I read on in your statement, the problem that you know will come up will be the person with bad health habits who expected to get into an insurance pool to have somebody else pay for his bad health habits. They are going to start complaining.

Mr. **Barnhart**. That's right. And that point is going to be one of our main concerns at this meeting next week. We are first wanting to measure acceptance. Our first goal is to measure acceptance of the membership of the kind of plan we are instituting.

Our second objective will be to monitor the growth, the continuity of the group. Is it thriving? Is it growing in enrollment?

And then, third, to try to get a handle on what are we really accomplishing by way of health improvement? Are we really doing something here that contributes in a positive way to the health and ultimately to the cost-effectiveness of the program?

Senator **Durenberger**. Do you have a view about that last issue as we move into the future? Obviously, in the past, insurance has meant spreading the risk through a pool of some kind; but when the cost of the abusers in the pool, or the chronically ill, or those who through no fault of their own are seriously sick, when the cost of providing sick care becomes so large that the rest of the pool starts to resist these costs, you have a problem. And that is what is happening in America.

Mr. BARNHART. Very definitely.

Senator DURENBERGER. That is clearly the problem. So some would say, "Well, push the abusers out of the pool." We can't do that in this country. But I take it we end up with some hybrid of some kind, where you maintain some of the benefits of pooling the cost but also you have a system by which those who are the higher users in the system are going to pay more to be part of that pool. Is that where it is sort of headed in here with the use of differential premiums, cost-sharing, and a variety of other mechanisms?

Mr. BARNHART. That is correct, Mr. Chairman. In this Illinois Health Improvement Association Program, the range of these reclassification rates, as it is now designed, is intended to range from 70 percent of standard. Standard would be the 100-percent level if there were no reclassification—the price that everybody would pay if there was no differentiation. The discounts are now designed to go down to 70 percent, and the surcharges up to a limit of 200 percent. So as time goes on, no one is eliminated from the pool, but the abusers or those who submit the high claims, would eventually gravitate toward the 200-percent level. But they would not be terminated; they would not be disqualified from participating in the pool.

Senator DURENBERGER. In that kind of arrangement are you exploring some of the quid pro quos? Let me use a simplistic example, and that is: I may have full or nearly full coverage for dental work but only if I can prove that I have had a dental health examination at least every 6 months. If I neglect to do my dental health examination every 6 months, which is also paid for in the plan, then why should the plan pay for the dental work that could have been discovered? Does that get built into these kinds of programs?

Mr. BARNHART. The intention is to do that, in time. We are moving into the program phase-by-phase as we can get things cranked up. But that kind of thing is intended to be introduced in time; so that, to maintain a favorable classification, a person has to show some evidence of continuing regular attention to preventive health.

Senator DURENBERGER. Well, very good. I appreciate your testimony a lot, and we will be back in touch with you some more.

Mr. BARNHART. Thank you, Mr. Chairman.

[Mr. Barnhart's written testimony follows:]

AMERICAN ACADEMY OF ACTUARIES

STATEMENT OF TESTIMONY TO
THE SUBCOMMITTEE ON HEALTH OF
THE SENATE FINANCE COMMITTEE

on behalf of the
COMMITTEE ON HEALTH of the
AMERICAN ACADEMY OF ACTUARIES

HEARING of June 14, 1985 concerning
Health Promotion and Disease Prevention Strategies
for Medicare Beneficiaries

PURPOSE

The American Academy of Actuaries ("Academy") appreciates the opportunity to submit professional testimony on the subject of this Hearing. This document contains comments on the actuarial aspects of three subjects relevant to this Hearing: (1) health promotion and preventive strategies in relation to age; (2) examples of actual experiments in these areas under insured health care plans; and (3) issues of cost and financial ethics with respect to preventive benefits provided under such plans.

BACKGROUND

The Academy is a professional association of over 7,600 actuaries involved in all areas of specialization within the actuarial profession. Included within our membership are approximately 85% of the enrolled actuaries certified under the Employee Retirement Income Security Act of 1974 (ERISA), as well as comparable high percentages of actuaries specializing in actuarial services for other employee and individual enrollment coverages such as life, health and disability programs. As a national organization of actuaries, the Academy is unique in that its membership consists of actuaries with expertise in all areas of actuarial specialization.

The Academy does not advocate any position on major public policy issues which are not actuarial in nature. The Academy views its role in the government relations arena as providing objective information and actuarial analysis to public policy decision-makers, so that policy decisions can be made with informed judgment. It is our belief that the training and experience of Academy members provides for a unique understanding of current and potential practices in health care financing. Our intention is to communicate that understanding in ways that will assist your Subcommittee and policy decision-makers generally.

COMMENTS

1. Health Promotion and Preventive Strategies in Relation to Age.

While this Hearing is directed specifically toward Medicare beneficiaries, it is important, even though obvious, to emphasize that promotion of good health and strategies of disease prevention need to be directed to all ages, from the prenatal on up. Had we Americans been more aware of the importance of this fact over the past half century, perhaps our Medicare bill could have been half of what it is. Fortunately, this awareness has been spreading and increasing dramatically during just the past decade, and this bodes well indeed for the general health status of Americans.

It is equally important to emphasize, however, that there is evidently no age so advanced that measures of health promotion and prevention cannot still be effective, even if these have been neglected throughout all of earlier life. Abundant case histories and examples have come to light in proof of this. No one is ever "too old", because of age alone. Almost any individual who is not already in the far advanced stages of presumably incurable or degenerative disease can still benefit from serious efforts toward health improvement.

Our comments, accordingly, we believe to be relevant to all ages of Americans, but also specifically relevant to our senior citizens covered under

Medicare - and to future senior citizens who WILL be covered under Medicare.

2. Examples of Actual Experiments under Insured Health Care Plans.

There have been quite a number of experiments directed toward health promotion and preventive measures under all kinds of health care plans. Among the most significant or widespread have been:

a. Extension of coverage to preventive expenses, such as coverage of annual physical check-ups and the like.

b. Cash refunds to individuals who have not utilized plan benefits over stated periods.

c. Premium discounts to "preferred risks", determined by habits relating to use, or rather non-use, of tobacco or alcohol, and by other characteristics such as height and weight, blood pressure, etc.

d. Renewal premium reclassification, involving renewal discounts or surcharges based on benefit utilization or continuing health evidence.

e. "Total care" programs, such as those frequently offered by health maintenance organizations.

These several kinds of experiments have led to varying degrees of apparent success or failure, in any particular case. Most of them involve some measure of offsetting disadvantage. For example, b. above (payment of cash refunds) raises the question of the extent to which those receiving refunds have maintained better health; or else are simply not submitting claims for benefits; or else, more seriously, are not seeking medical care they should have, for the sake of qualifying for the refund. The author of this Statement has had considerable experience with "return of premium" individual health care or disability policies. The experience shows that, without question, claim experience is more favorable, that is, total claims are lower, in the presence of the cash refund feature. But just what this may prove is another question. All we really know is that claim experience is lower, under such plans.

The author has more recently had experience with a program of type d. above, involving renewal premium reclassification. This program, while it seems to show considerable promise, only became implemented as of January 1, 1985, and considerable time is needed before apparent results can be evaluated.

The program is in use by a large voluntary association in the State of Illinois, with about 140,000 subscribing members and their dependents: more than a quarter million individuals in all. It is known as the Illinois Health Improvement Association, and, true to its name, has seriously endeavored to develop incentives among its members toward better health. The latest incentive has been the adoption of a renewal premium reclassification system, based BOTH upon a subscriber's benefit utilization of the health care plan during the preceding year or years, and also upon a subscriber's continuing or resubmitted evidence of good health. Several "tiers" of premium rate levels are provided for, ranging from 70% of the "standard" premium level, up to about 200% of the "standard" premium level.

A discussion of this interesting experiment was presented at one of the sessions of the 1984 Society of Actuaries Spring Meeting held in Atlanta, Georgia. A copy of the record of that discussion is attached to this Statement as an appendix. The discussion of this specific program is found on pages 247-251.

Premium reclassification programs of this kind are also prone to criticism. One significant criticism comes from among those who move "up the ladder" to the 200% of standard level. Some ask, "What is insurance for? We had claims, or our health has deteriorated. So now we pay more. Insurance should pool the experience of everyone: the healthy should help to pay for the medical expenses of the unhealthy." This "pooling" concept remains in the program, however, even though in a modified form. Those who have had no expenses at all, or who are in the most superb health, still pay premiums at a rate of 70% of "standard". Experiments at promoting better health, and incentives to that end, appear to be needed and we will have to see how effective this one may prove to be.

In the final section of this Statement, comment will be made concerning plans of type a., coverage of preventive expenses.

3. Issues of Cost and Financial Ethics with Respect to Preventive Benefits.

There have been many experiments seeking to incorporate coverage of preventive expenses. The simplest example is perhaps a benefit provision that provides payment for one regular physical check-up annually; e.g., up to $50 or $75 allowable each year for this.

This can present a problem as to cost: the amount by which the premium must be increased to include the preventive benefit. Ideally, one would hope that every member of the plan would utilize the benefit and get the check-up. But if this goal is realized, the additional premium to pay for, say, a $75 annual physical, must exceed $75, due to administrative expenses, state premium taxes and so on. The resulting question, then, is whether it is financially appropriate to charge more, by way of premiums, than the members would pay on their own for annual check-ups. Some State insurance departments refuse to approve these preventive features, for this reason. In theory, the LONG TERM objective is a healthier group, so that eventually premiums will be lower, not higher.

But it is hard to realize that objective, because another principle of the marketplace gets in the way: competition. At the outset, plans with liberal preventive benefits have great trouble competing in price with other plans that do not contain such provisions.

This is one of several reasons why the Illinois Health Improvement Association instituted its premium reclassification program instead. Members have to pay for their own physical check-ups. But if this leads to their qualification for a renewal premium discount, they realize a direct financial benefit for their attention to their health, a premium savings that can rapidly exceed whatever price they paid themselves for preventive medicine.

So various experiments have been tried, or are now being tried. Those of us in the Academy of Actuaries who have specialized experience and knowledge in this broad area would be glad to share this experience and knowledge with your Subcommittee and staff to the extent possible and in whatever manner would aid your objectives toward better health promotion.

I respectfully ask that this Statement and attached appendix be included in your record of this Hearing.

E. Paul Barnhart

E. Paul Barnhart, Chairman
Committee on Health
American Academy of Actuaries

APPENDIX

THE PROFESSIONAL CHALLENGE OF INDIVIDUAL MEDICAL INSURANCE

Moderator: WILLIAM F. BLUHM. Panelists: NOEL J. ABKEMEIER, E. PAUL BARNHART, CHARLES F. LARIMER. Recorder: STEPHEN A. RILEY

Insurers have been getting out of the individual medical expense market. This session will address the implications of such a decision and will cover:

. Nature of the problem

. Viability of individual medical products

. Challenge to the actuary

. Consequences of withdrawal

. Alternatives to withdrawal

Particular emphasis will be placed on the challenge to the actuary, with stress on education and research demands.

MR. WILLIAM F. BLUHM. We have modified the outline that is in the program. The structure which we now propose is to first describe the problem as we now see it in the individual medical market, secondly, to describe some of the potential solutions that the panelists see, and thirdly, to discuss some of the challenges that we see facing the actuary.

Charles Larimer has been with Health Care Service Corporation in Chicago for the last three years. He was recently promoted to Actuary and officer responsible for pricing and product development for individual small group and HMO products. Before Blue Cross he was at CNA Insurance for six years in group pricing and product development.

Paul Barnhart has been in the health insurance field for his entire career, starting at Occidental in California in 1954. He opened a consulting practice in St. Louis in 1964, and has been the author of many papers in the Transactions. Two of these are on the exam syllabus including a 1960 paper on Adjustment of Premiums on Guaranteed Renewable Policies. He was elected to the Society Board of Governors in 1970, was Vice President in 1973, and became the President elect in 1977. He helped found the Health Section in 1982, and was elected to its first council and was twice elected as chairman of the council.

Noel Abkemeier is Senior Actuary, responsible for individual health at Allstate Life. He is the chairman of the Basic Education Subcommittee of the health section, and chairman of the Research and Development Committee of the HIAA, where the main project is the study of the Health Care delivery system in 1990. He is the chairman of the HIAA Actuarial Task Force on unisex pricing and is a former chairman of two HIAA committees - one the Individual Actuarial Sub-Committee and the other the Task Force on Cost Containment.

MR. NOEL J. ABKEMEIER. Individual medical insurance is an area of insurance and actuarial expertise which has been virtually devoid of positive news for a decade and has generally brought headaches and frustration. The common picture has included financial losses, withdrawals by insurers from the marketplace, or, at best, a product modification intended to protect the insurer. In order to look toward the future and determine if we are in store for more of the same, it is best to first analyze the current situation; then we can identify the options open to us.

The environment to be considered includes forces external to the insurance company and others within it. I would like to comment on each kind, starting with the external forces.

EXTERNAL ENVIRONMENT

I see four categories of external influences: economic forces, consumer attitudes, the limitations inherent to the nature of the individual policy, and regulatory limitations. Each of these is a complex challenge in itself.

Economic Forces

The dominant economic problem from the perspective of the consumer is the affordability of the coverage. In some areas a comprehensive major medical policy for a family might cost 25 percent of the median family income. The tax deductibility which mitigated the burden has been eliminated and the deductible has been increased from 2 percent to 5 percent.

This unaffordability for many has been caused by inflation in medical costs which has been brought about by general inflation, deductible erosion, an increase in the quality of medical care, an improvement in the status of medical personnel, the aggressive pursuit of malpractice claims, technological improvements, profit oriented hospital charging methods, and cost shifting. In relation to cost shifting, it is possible we are beginning to be affected by a new kind. You are familiar with the passing of extra costs to insurers and individual payors because the federal government and some service corporations paid less than a proportionate share of costs within a hospital. Now, preferred provider arrangements have the potential of shifting costs to the detriment of individual policy insurers if the discounts become too deep or if preferred provider arrangements have hospitals merely trading business at discount rates.

The high expense loadings of individual insurance exacerbate the affordability problems caused by the various kinds of inflation. The 55 percent loss ratio of an individual policy is much more likely to raise concerns than is a 90 percent loss ratio that might relate to group insurance.

The various contributors to the affordability problem mainly fall beyond the control of the insurer, but some can be addressed. One exception is deductible erosion, which can be combatted with dynamic deductibles in new products and insurer initiatives in the form of product upgrades in existing business. The cost of emerging technology can be avoided with the elimination of the coverage of experimental procedures; however, this delineation may be difficult both in contract drafting and in interpretation at the time of claim. Finally, the imposition of inside limits upon the policy will aid affordability but the cost is paid by the consumer in the decreased adequacy of the coverage. I will comment more on these in the discussion of the viability of individual medical insurance.

The principal economic problem from the perspective of the insurer is the unprofitability or marginal profitability. This is born of the unpredictability of claim cost increases and the difficulty of responding to them on a timely basis. This has been caused by cost shifting and the higher inherent level of medical cost inflation. Life actuaries have the luxury of knowing their insureds will die almost on schedule or, if not, at a more favorable rate and that the benefits are unvarying. We health actuaries know the frequency of medical expense claims with less precision, must adjust to the evolution of medical care standards, and must respond to the changing practices of providers and governmental bodies. Little suggests that this environment will change.

The impossibility of predicting the changes in the pricing factors leads to premium inadequacy. The necessity of demonstrating to regulators through experience the need for higher premiums further aggravates the problem.

Consumer Attitudes

The second external environmental factor is consumer attitudes. The strongest influence is the high value that each person places on his health and the desire to maintain that health. In the absence of incentives to limit expenditures on health care, the consumption of health services grows as new treatments emerge and as expectations for good health rise. Individual medical policies have generally lacked sufficient incentives to limit usage and change consumer attitudes.

The consumer's lack of concern could be mitigated with a larger assumption of risk by the consumer through coinsurance and the use of larger deductibles. In general, consumers have been reluctant to assume a greater responsibility for the financial risk. It is only when unaffordability has been imminent that there has been increased risk sharing. Problems are solved only where they start to become painful; perhaps that point has arrived for individual health costs and the result will be cost sharing.

The high cost of individual medical insurance has made cost a concern of the consumer with the result that cost shopping is common before purchase and regularly thereafter. This creates more expense and antiselection and thus aggravates the previously mentioned cost pressures for both the consumer and the insurer.

Product Limitations

There are a number of responses to the problems which are possible in other forms of medical expense benefits but are unavailable in the individual policy. The use of preferred provider arrangements and preapproval of noncritical care is not practical because of the geographical spread of the insureds. Education of the insureds about less expensive alternatives is difficult because of the loose ties between the insured and the insurer.

Unilateral improvement of deductibles is not possible on most business currently in force. The timely adjustment of rates is not possible because of the need for multiple state rate approval and because these increases tend to be obtainable only after the development of unfavorable experience. The process of multiple filings and approvals in itself adds cost.

The fact that the product is sold to an unsophisticated buyer and is often sold by an agent who does not specialize in the business leads not only to oversimplified products but also misunderstandings.

The contract itself is static so that changing business practices by hospitals may make contract limitations ineffective in some policy exclusions. For example, treatment in certain types of facilities, such as drug and alcohol treatment centers, may have been excluded by contract, but the enforcement becomes difficult when such facilities no longer are free standing but are blended into a hospital complex. Thus the facility becomes a "hospital" and treatment must be reimbursed. Finally, there is no Coordination of Benefits, thus duplication of insurance is possible and cost saving incentives can be rendered valueless.

Legislative and Regulatory Limitations

The final external factor is the web of restrictions imposed by intense state regulation. The process itself is quite expensive and the requirements it brings create new challenges for the insurer. Mandatory coverage of emerging treatment areas and mandatorily optional coverage of benefits vulnerable to anti-selection impose new liabilities on insurers. This has occurred most recently in coverage for alcoholism, mental illness, and drug abuse.

The possibility of mandatory unisex pricing exists and this would present significant actuarial challenges. Males would be sharing the cost of maternity care, males generally would be subsidizing the cost of female benefits at most ages, and females would subsidize at other ages. Massive market dislocations would affect everyone and would favor some vendors while placing others at a severe disadvantage. A factor of chance would be introduced into pricing for several years until the market restabilized.

INTERNAL ENVIRONMENT

The external environment has created a reluctance to commit company resources to individual medical insurance. None of the characteristics create optimism when contrasted with the potential of life insurance or annuities. Over the short term, medical expense insurance is relatively labor intensive for legislative and regulatory compliance, experience analysis, claim handling, and general administration. In the mid-term, the profitability is uncertain on an annual and a continuing basis. Also, the product does not present much potential for investment profit, an item catching the eye of management. Over the long term, the growth potential is unclear. Although premiums may grow, the market may be further eroded by baby group insurance and HMO's. However, although individual medical insurance is difficult to identify as a high priority line, it may complement the marketing of other lines of insurance and merit corporate support. Charlie has some comments also on the environment.

MR. CHARLES F. LARIMER. At Blue Cross Blue Shield of Illinois the largest problem we've had to deal with in the last few years in our individual health line has been the problem of anti-selection during periods of high lapse rates. Healthy individuals have had a much higher lapse rate than unhealthy individuals. Of course this stems from all sorts of other problems and then leads to other problems.

We went through a long period of strict state regulation where adequate rates were not allowed to be charged. When this regulation relaxed a little bit and proper rates were allowed to be charged, the block of individual business declined rapidly as these rates were installed. We were in a period of high inflation which made the problem even worse.

Cost containment and benefit cutbacks were tied into all of this, as a means of reducing the magnitude of the rate increases necessary, which obviously were accentuating the lapse problem.

Having gone through this period of high lapse rates caused by rate catch up and inflation, we now see our problem as "How does one save a pool that has already been subject to high anti-selection through the lapse process" or in other words, "How do you bring new blood into an old pool?"

The viability of individual medical products is being threatened by this lapse problem. In order for an individual medical product to be viable, I feel that these products must adapt and borrow, like any good evolving organism. Many of the ideas borrowed in individual health come from ideas originally tested in the group lines. I feel that this must continue. There also are some schemes coming from other areas, such as automobile insurance, that are currently being considered. Now Paul will discuss some of the potential solutions to this problem.

MR. E. PAUL BARNHART. I rather hesitate to use the words potential solutions. I rather think in terms of some devices that might serve to mitigate the problem, but I would not go so far as to suggest that these things would actually solve it. I do think, however, they would help significantly.

Incessantly escalating cost, utilization rates and anti-select lapsation have become almost a "law of physics" under individual medical insurance. The result, as we are all too sadly aware, is ever expanding cycles of larger rate increases, attended by still greater anti-select lapsation, or else large scale non-renewals by affected insurers and withdrawal of available coverage. Alternatives to these cycles are desperately needed.

There has been a lot of attention given to cost containment in dealing with the problem in this area, but I think insurers, particularly in the individual medical expense area, also need to deal with devices to mitigate this problem through benefit adjustments and various measures that can help to control the rate at which premium rates increase. Two devices that should be more widely used are indexing coinsurance factors and limits, and indexing deductibles. For example, the coinsurance factor for a plan might start out paying 90% of expenses above some deductible up to some out-of-pocket limit with the coinsurance percentage indexed. There are obvious limitations to indexing. For example, if you start out at 90% coinsurance and drop it 5% each year to offset cost increases, it is impractical to visualize that going beyond 50%. The indexing of deductibles, I think, shows more promise, because it both has more effect and at the same time its reasonableness can be better understood by consumers, and because it is possible to index deductibles at some rate that has a reasonable relationship to the rate of inflation itself. The coverage in the long run, I think, remains more viable and more useful to the insurer.

Plan deductibles and/or indexing coinsurance factors and limits can be designed to index:

a) Automatically, at an appropriate "objective" rate, such as the medical price index.

b) At fixed pre-determined rates. For example 5% a year might be one way of approaching this at a known fixed pre-determined rate. The trouble with this being that it cannot respond to radical changes in the rates of inflation in utilization.

c) As automatic offsets to alternative increases in premium rates or, alternatively, in underlying trend rates. For example, to offset any rate increase or underlying cost trend rate, in excess of 15%. The indexing of a deductible for example might be carried out to the extent needed to hold the increase in premium rates or in underlying trends to a maximum of 15%, thereby placing a ceiling on the rate which premium rates actually can be increased in the renewal years.

The following chart* illustrates the effect of indexing deductibles as an offset to underlying trend rates in excess of 15% as an example threshold level. Let me emphasize that while these figures are meant to be realistic, they are still purely illustrative, and I have purposely not defined any specific plan of benefits related to these costs and percentages.

I am assuming that, for a particular age/class cell, or as a composite of the coverage in force, the continuance probability functions shown approximate the on-going claims experience. The "initial" function shown defines the claim pattern expected when a block of policies is originally issued. From the initial probability function it can be seen that the probability of a claim reaching $40, once it has begun, is equal to 1 (substitute D=40 in the function). The probability of D (claim dollars) higher than 40 is determined by the formula for $P^{(D)}$. In addition to the above continuance, the initial incidence rate is assumed to be 50% at the $40 point. In other words, half of the policyholders or individuals covered are expected to reach medical expenses in a given year equal to $40. The probability function takes over and measures it from that point on out.

From this function, we can readily calculate the expected claim incidence rates and annual claim costs for various front-end deductible levels, as illustrated. Similar calculations can readily be made for additional plan features such as co-insurance corridors and percentages, and out-of-pocket limits beyond which 100% insurance coverage takes effect, up to any plan maximum benefit level. One million dollars is the maximum assumed per claim, in the illustrative calculations.

The first row of numbers under line A represent a series of choices as initial deductible. This plan might be marketed by some carrier with that

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*Chart appears on the next page

AMOUNT OF DEDUCTIBLE INCREASE TO OFFSET COST INCREASE

INITIAL COMPREHENSIVE COST CONTINUANCE FUNCTION: $P^{(D)}=\left(\frac{390}{350+D}\right)^{1.6}$

(PROBABILITY THAT COVERED EXPENSE, ONCE STARTED, WILL REACH D DOLLARS)

$1,000,000 MAXIMUM — INCIDENCE RATE AT $40 EXPENSE = 0.50

A. INITIAL DEDUCTIBLE:	200	500	1000	2500	5000	10,000
1. ANNUAL CLAIM COST:	261	201	151	96	65	43

B. 15% INDEX ADJUSTMENT: $P^{(D)}=\left(\frac{448.5}{402.5+D}\right)^{1.6}$ — INCIDENCE RATE AT $46 = 0.50

1. ADJ. ANNUAL CLAIM COST:	309	242	185	118	80	53
% OF A1:	118%	120%	123%	123%	123%	123%
2. DEDUCTIBLE CHANGE TO HOLD COST TO 15% INCREASE:	230	575	1150	2875	5750	11,500
3. TO HOLD TO 0% INCREASE:	396	831	1557	3735	7364	14,622
% OF INITIAL DED:	198%	166%	156%	149%	147%	146%

C. 30% INDEX ADJUSTMENT: $P^{(D)}=\left(\frac{507}{455+D}\right)^{1.6}$ — INCIDENCE RATE AT $52 = 0.50

1. ADJ. ANNUAL CLAIM COST:	358	285	220	142	97	64
% OF A1:	137%	142%	146%	148%	149%	149%
2. DEDUCTIBLE CHANGE TO HOLD COST TO 30% INCREASE:	260	650	1300	3250	6500	13,000
3. TO HOLD TO 15% INCREASE:	422	900	1696	4087	8071	16,040
% OF INITIAL DED:	211%	180%	170%	163%	161%	160%
4. TO HOLD TO 0% INCREASE:	652	1256	2263	5282	10315	20,380
% OF INITIAL DED:	326%	251%	226%	211%	206%	204%

choice of deductibles available. The choice of initial deductible ranges from $200 up to $10,000 in this illustration. Using the 50% incidence rate along with the probability function, we can calculate the theoretical annual claim cost. The initial annual claim costs are shown on line A1 of the chart, and represent the benefits in excess of the respective series of deductible choices.

Next, assume that for the second year the plan is in effect a 15% trend rate (covering unit cost and utilization) is expected. To adjust for this assuming the total relative pattern of claim cost probabilities persists, the probability function must be adjusted as shown, increasing each internal constant by 15%: 390 becomes 448.5, and 350 becomes 402.5. Further, the starting point at which the function is assumed to define the continuance, and for which the initial base probability of claim is 50%, must likewise be adjusted by 15%, from $40 to $46.

Line B1 shows the resulting indexed claim costs, assuming no change in the deductibles. As is well known, the claim costs in excess of the fixed deductible increase by more than 15%, the rate rising with the size of deductible: in this case from 18% for a $200 deductible to 23% for a $2500 deductible. The rate tends to level out, in part because I have not changed the $1,000,000 maximum. With a $5,000 or $10,000 deductible and a 15% trend rate the function used in this illustration does assign a little bit of cost to claims going over a million dollars. For example, the $53 claim cost on line B1 for a $10,000 deductible plan includes about $1.50 from claims over a million dollars. The maximum is another plan element that, of course, can also be indexed. Indexing the maximum would probably help in the acceptance of the program by policyholders to at least show that their maximum was being increased along with their deductible.

Line B2 shows the amount by which each deductible must be indexed to stabilize the claim cost at the same 15% index rate as that which applies to the underlying trend. Each deductible, as is obvious, must increase by the same 15%.

Next, line B3, shows the increase in deductible, by amount and percentage, that would be necessary if the objective were to hold the claim costs constant. These percentage increases reduce by size of deductible, from 98% for the $200 deductible, now $396, to 46% for the $10,000 deductible, now $14,622. These increases are quite large, and clearly impractical, since few policyholders would accept such radical adjustments and resulting dissatisfaction and lapsation would be worse than ever. You pretty much have to concede that the premium rates are going to have to increase. What has to be done is to work out the happy medium. What is the reasonable combination of increasing rates along with indexing deductibles? My own opinion is that the best medium is the 15% rate increase in the deductibles. Indexing at the same rate as the expected underlying trend is a reasonable alternative to uncontrolled cost increases, and really quite logical. At today's rates of cost escalation, the insurance buying public simply has got to get used to the idea of indexing deductibles, or other equivalent cost control devices.

Finally, the chart shows the effects of a 30% trend rate, along with similar indexing controls designed to limit cost increases to 30%, 15%, and again 0%. Again, the 30% control indexing is within reason, while attempts to limit cost increases to lower rates become increasingly impractical. As before, a 30% trend control means increasing the deductibles themselves by the same 30%.

Before moving on to other comments, let me also mention that this same kind of indexing device works well in relation to inside limits, such as hospital room, surgical and medical limits or amounts.

MR. LARIMER. In terms of plan design for cost containment, there are several experiments under way in the Blue Cross-Blue Shield system today.

In the Minneapolis/St. Paul area individuals are being allowed to enroll in the Preferred Provider Organization (PPO) initially set up for groups. The PPO network is quite extensive in the area. Nearly all of the twenty-seven or twenty-eight hospitals in that area are included as eligible hospitals. Having such a product allows much easier use of various cost containment techniques such as concurrent review and preadmission certification. In fact most utilization review programs for the individual contracts in the Minnesota PPO were just a simple expansion of those already in place for group business.

In the Boston area the Blues will be offering an individual medical product that includes preadmission certification and concurrent review. This product will have a rate difference around 5% vs. their Major Medical product that does not have the preadmission certification and concurrent review. They have plans to expand their program across the entire state if it works out well in the Boston area.

The Federal Government is also getting into the act of borrowing from the group ideas and expanding into individual lines. Recently there have been expanded efforts to persuade Health Maintenance Organizations (HMO) to enter the individual Medicare Supplement market. As part of Tax Equity Fiscal Responsibilities Act (TEFRA), the rules for reimbursing HMOs were changed to make it more economically interesting for an HMO to enter the individual over 65 market. The new regulations let the HMOs keep a larger percentage of any profit generated, or at least return less of it to the government. Former rules would only let an HMO keep 1/2 of the first 20% of premium profits and thereafter all the profits would go to the government. The new rules, in essence, give the HMOs a little bit less money to begin with but to the extent that the HMO can make a profit they do not have to give any of it back to the government.

In each case much of the what I've called profit must in actuality be returned to enrollees in the form of expanded benefits. Also the new rules have fewer reporting requirements for some HMOs.

Generally the new HMO Medicare Supplement rules have not yet been implemented other than in a few demonstration products around the country. The final regulations interpreting the law have not yet been published. The word out of Washington is that the government actuaries are the ones getting cold feet on the issue. The initial intent from the government side was that such a program should at least save the government in the long run. Budget neutrality pops up in many of their discussions. The fear of the government, which will be reimbursing the HMOs on a capitated or per head basis, is that the HMOs will be skimming the healthy lives. This would leave a non-HMO population that would cost, on a per capita basis, more than the current population.

This is the same argument that is often thrown out today in describing or explaining why an HMO has lower hospital utilization than a non-HMO population. Those that are currently seeing a doctor are not likely to switch doctors, which is usually required when they move into an HMO. The theory is that an HMO starts with a very select, or healthy group of people. In any event, for those of you who deal heavily with individual Medicare Supplement type policies, you will shortly be having new competitors throughout the country.

In terms of new pricing mechanisms, at the Illinois Plan we are now giving heavy consideration to a band rating concept for a large pool of individual contracts outside the Chicago metro area. This idea is borrowed primarily from automobile insurance, and has also been used in some small group situations. Lest I sound too original on this topic, Mr. Barnhart, acting as a consultant for the association that sponsors these individual contracts, was the one who actually made the first proposals to my company about this concept.

The theory behind why a band rating mechanism might save a dying pool, or at least slow down its deterioration, can be surmised by looking at the statements that are on this slide.

Slide 1

	Force on Lapse	Prob. of Lapse
(1)	(a): Health Status Improves	Increases
	(b): Health Status Deteriorates	Decreases
(2)	: Absolute Amt. of Rate Change Increases	Increases
(3)	: Rate Diff. vs. Ind. U/W rates Increases	Increases

The first statement is that the lapse rates are very dependent on health status. The probability of a lapse increases as the health status improves, or conversely the more unhealthy a person is the less likely that individual will be to leave the pool.

The second statement is that the probability of a lapse increases as the absolute amount of a rate change increases. This is tied closely to the irritation level generated after receiving a rate increase notice, as well as economic reasons.

The third statement is that the probability of a lapse increases as the relative difference between the pooled rates and new individual underwritten rates increases.

All of those statements are fairly obvious, and have been observed over recent times in studies of our own business.

The intermediate goal of our band rating system will be to generate lapse rates that do not vary so greatly by health status. Of course we are trying to reduce the overall lapse rate.

By making rate increases for healthy policyholders smaller (with reference to statement 2) and the rates closer to underwritten rates for those healthy individuals (with reference to statement 3) the band rating mechanism will make lapse rates less dependent on health status (reference statement 1).

Again, the intermediate goal is to reduce lapse rates for the healthier policyholders. This, in turn, we hope will slow down and possibly reverse the direction towards an assessment spiral.

It is important to note that the purpose is not to make each cell self-supporting. In general, the policyholders in the cells for the healthier policyholder will be expected to make a positive contribution to the pool, and vice versa.

This next slide shows a generalized description of the band rating concept we plan to implement. Once a year we will review claims on the individual contract level and change the band for those individuals. We are setting a limit of an increase or decrease of only one notch per year and each notch will be worth 5%.

Slide 2

Rates as a Percent of Base Rates

Band	U35	35-44	45-54	55-64
1	70 %	75 %	80 %	85 %
2	75	80	85	90
3	80	85	90	95
4	85	90	95	100
5	90	95	100	105
6	95	100	105	110
7	100	105	110	115
8	105	110	115	120
9	110	115	120	125
10	115	120	125	130
11	120	125	130	135
12	125	130	135	140
13	130	135	140	145

Expected Positive Contribution to Pool

Expected Negative Contribution to Pool

Range of Eligible Bands may vary by age.

Band Moves: Based on Paid Loss Ratio or DRG.

Move only 1 band per year,

up/down/same

There are several methods by which the system could have the bands changed from year to year. The most simple method is on a paid loss ratio basis or some other form of loss ratio. A more sophisticated method would be on some DRG or diagnosis related group basis.

The next slide shows how a rating scheme might be constructed. Current members would be brought in to this new pool, rolled over into this new pool at one level. A different level for those passing underwriting would be set. It would be possible to work in such things as no smoking discounts in the band rating concept by allowing non-smokers to be brought in at one band level and smokers in at another.

Slide 3

Initial Year - Possible Structure

Age	Base Rate (= 100 %)	Band for Current	Band for New Entrants & Current who pass Ind U/W	
			Smoker	Non-Smoker
U35	$30	100 %	80 %	70 %
35-44	40	110	85	75
45-54	50	120	90	80
55-64	60	130	95	85

In the initial year we would probably allow current members to submit to underwriting and be moved to the band closer to that of new entrants. New entrants would be subject to pre-existing condition limitations that existing members would not. Therefore we would not necessarily move existing members who pass underwriting all the way down to the level for new entrants.

Management systems to keep track of this band rating system will of course cost much in terms of time and dollars. We believe that it will pay off in the long run.

The actuarial analysis of such a mechanism gets to be tricky. Solid projections by cells will be needed. Each cell in such a system will not necessarily have a rate that is expected to be self-supporting. Therefore, a fair degree of conservatism is needed in the cell distribution projections. It is very important not to get into a chain letter type philosophy when setting rates. This could happen with overstated projections of new members at rates that would be giving relief to those in the higher rated bands.

These problems of cell projection actually exist even when band rating is not used. Frequently analysis will assume that a pool will continue to have the same percentage of healthy vs. unhealthy lives, other than aging aspect. This is really just an implied assumption, that often is not true.

One of the troubles with the band rating analysis is that non-actuaries will be projecting a large influx of new members at rates which positively contribute to the pool. Much caution is needed here.

If after several years of actuarial studies, the mathematical relationships of rate increases vs. lapse rates vs. anti-selection were known, it would be solved for the maximum profits in a given year. Some of the variables would be the number of band unit changes allowed per year, and the size of band increments. However, my suggestion would be to start slowly and not attempt to maximize short term profits vs. long term considerations.

In setting up a system like this, one must be cognizant of policyholder, public, and insurance department perceptions.

Maximizing profits for a particular year could be very contrary to the long term viability of such concept.

If either policyholders, public or the insurance department felt a band rating concept were contrary to the best interests of the insured public, then all sorts of external problems can be created. The general perception by policyholders, the public, and the insurance department is that insurance is to protect policyholders against such things as high claim experience and that this band rating system is really just taking away from that insurance that they purchased. They may perceive that the insurance company is retroactively making them pay for their claims that the insurance was supposed to cover.

A great deal of actuarial analysis must be done in implementing the band rating concept. In fact, some of our marketing staff has described the whole thing as an actuary's dream. Many calculations must be done on the policyholder level and a much more detailed explanation must be given to the policyholder. Now we will turn it over to Noel.

MR. ABKEMEIER. I would like to comment on both the indexing concept which Paul described and the banding concept which Charlie described.

At Allstate we offer a product which reflects the deductible indexing design concepts that Paul just mentioned. It provides comprehensive benefits but contains inside limits. Benefits for room and board, surgery, intensive care, private duty nursing and others are expressed as multiples of the room and board benefit. The deductibles similarly are expressed in terms of the room and board amount. The customer selects the desired room and board benefit from a range around the average semi-private cost in his area. In this fashion he can choose the level of benefit for which he can afford both the premiums and the necessary cost sharing. The inside limits provide some protection to the insurer.

In subsequent years the room and board limit, the related benefits, the related deductibles, and the premium all increase in proportion to the Hospital Room Component of the Consumer Price Index. This premium increase is added to a Yearly Renewable Term (YRT) increase. This maintains benefits of similar adequacy as at issue, eliminates deductible erosion, protects the insurer against uncontrollably increasing costs, and maintains the same relationship of premiums to benefits as existed at issue. In general, this satisfies the needs of both the consumer and the insurer.

The banding concept which Charlie described can not only serve to revive a dying pool, but also is a way to gain and retain good risks. A slightly more dramatic version of this band system is to express it in terms of discount percentages. Initially, the insured may get a non smoker discount but this would be reduced and eliminated over three years, or so. A discount of perhaps 15 percent could be earned beginning in the third year if claims are low in the most recent year and another 15 percent on subsequent years if claims are low over a span of several years. This could be faster moving and more responsive to experience and would be more attractive for marketing. The customer could see how he can merit an attractive premium. By converting the bands to discounts, the "Actuary's Dream" can become "Marketing's Dream." The method also can serve as an incentive to reduce costs by using lower cost policy benefits.

MR. BARNHART. The Regulatory Definition of "Guaranteed Renewable".

The regulatory definition of "guaranteed renewable" should be expanded to include plans with coverage elements, such as deductibles, subject to objectively determined indexing not subject to the optional control of the insurer. Restriction of the insurer's right solely to changing the premium defeats the long-term viability of guaranteed renewable individual insurance, to the detriment of the public interest, and has, in my opinion, become obviously impractical.

An open mind, on the part of all parties (actuaries, marketing executives, agents, and especially regulators), with respect to use and experimentation with indexing devices is essential if individual medical insurance is to continue to play a useful role for the public. There is no legitimate reason, in my judgment, why the essential guarantees implicit in the concept of "guaranteed renewable" individual insurance cannot be preserved by expanding the regulatory definition to include indexing devices sufficiently controlled so as not to be abused by insurers.

"Level" Premiums Based on Issue Age Don't Deserve to Be Abolished Just Yet.

In combination with the indexing plan elements described, this pricing mechanism can regain the its viability. To restore this viability, however, regulators should abandon their general opposition to long term projections of cost indexing at reasonable rates, particularly in combination with rate increase dampening devices such as those I have described. Large rate increases inevitably provoke disastrous anti-select lapsation and deterioration in renewing business and are the real villains to be attached, rather than higher initial rates resulting from reasonable long-term trend assumptions used in calculating level premiums. After all, if the prospective buyer thinks some policy is overpriced at the outset, he simply need not buy it. But if it is his renwal premium that jumps by 50%, that is when he complains to the insurance department, and when he may have no recourse but to drop his insurance protection.

From the regulatory point of view, some objective rule is desirable beyond merely "reasonable," with respect to limits on long-term trend projection rates. One practical basis would be to limit the maximum trend or index projection rate to not exceed the ultimate rate of interest assumed in calculating percent values, or to that rate reduced by 1 or 2 points.

Any reasonable device for dampening the size of rate increases deserves open-minded consideration. Such dampening is essential, if disastrous anti-selection and prohibitive rate increases are to be softened. Regulation makes a serious mistake when it forces insurers into YRT rating that simply maximizes renewal rate increases through the combined impact of advancing age, advancing costs and utilization rates, and advancing anti-select deterioration. Maximized rate increases simply maximize renewal anti-select deterioration, and ultimately destroy the value of individual medical insurance to the public. It is close to unaffordable right now.

To illustrate what I mean, the following chart* compares the rate renewal history of YRT and "Level" to Age 65 rate structures, for two plans which are otherwise identical as to benefits and relative assumptions. Both rate structures anticipate 60% loss ratios over the policy lifetime.

In both cases, I have assumed the same underlying 15% trend rates, both contracts involving the same indexing of a $1000 initial deductible so as to limit the claim costs to 15% annual increase, except for expected anti-selection. Both structures assume yearly rate adjustment.

In both cases, anti-selection is assumed to increase the morbidity level each renewal year by an excess 3%, even though the rate increases are much larger under the YRT structure; hence this comparison is actually biased in favor of the YRT history, if biased at all.

Both structures assume 10% interest for 10 policy years, and 8% thereafter (the YRT rates 10% for each year shown). The "Level" rates provide for 5% underlying trend each year, all the way to age 65, which is 3 points lower than the ultimate interest rate of 8%. Thus, the additional new rate each renewal year needs only to cover the next "level" layer providing for the remaining 10% of the underlying trend; the increment of anti-select 3% excess morbidity due to lapsation is also provided for.

Upon renewal, the YRT scale also picks up its share of the wear-off of new issue select morbidity, which is also provided for in the Level structure, with a 3 year select period.

As shown, the yearly renewal rate increases for the YRT structure tend to average more than twice as large as the corresponding "level" increments, and for original issue ages 45 and over, after only 3 years the total 4th year YRT renewal premium actually exceeds the 4th year level premium in absolute terms.

* Chart appears on the next page

COMPARATIVE HISTORY OF RENEWAL RATE INCREASES
YRT vs. "LEVEL" PREMIUM STRUCTURES:

OTHERWISE EQUIVALENT BENEFITS AND PREMIUM ASSUMPTIONS
$1000 ORIGINAL DEDUCTIBLE - $1,000,000 MAXIMUM - 60% LOSS RATIO

ISSUE AGE	ORIGINAL PREMIUM	INCREASE AT EACH RENEWAL YEAR 2	YEAR 3	YEAR 4	TOTAL PREMIUM YEAR 4
		YEARLY RENEWABLE TERM RATES			
25	$230.01	$65.46	$65.47	$80.36	$441.30
30	254.82	79.25	84.03	105.76	523.86
35	313.97	101.51	107.28	134.27	657.03
40	396.02	129.75	137.44	172.49	835.70
45	507.65	170.99	184.74	233.19	1096.57
50	670.79	223.27	236.82	296.16	1427.04
55	865.40	286.47	304.11	381.61	1837.59
		"LEVEL" PREMIUM TO AGE 65 RATES			
25	$375.01	$38.68	$41.14	$44.76	$499.59
30	451.26	46.86	50.14	54.69	602.95
35	551.40	57.32	61.40	66.90	737.02
40	670.44	69.74	74.80	81.42	896.40
45	808.12	84.17	90.43	98.28	1081.00
50	955.71	99.67	107.32	116.52	1279.22
55	1096.60	115.32	125.36	136.84	1474.12

Which series of rate increases would you rather contend with if you were the policyholder, living on a budget? I would rather be in the bottom group. And give it another two or three years, and you may not even be able to afford to be in the upper group. If you're age say 45, your rate is going to be $1500, $1600, $1800 a year, and while it keeps going up, either way I think the increases are much easier to live with for the person on a budget if he is in the bottom group. I didn't know how this chart was going to come out until I tried this, and I was surprised, quite frankly, about how much it really shows the advantage of the level premium basis. I didn't think by the fourth year the annual renewable term rates would have caught up with the level premium rates, but they do, under the scenario that is being used here. So, I think the level premium approach deserves to be thought about a little more, but I think it is only going to work if long-term projection of trend rates, at some reasonable rate not exceeding the ultimate interest rate, is built into the rate calculation, and secondly, if the indexing of ~~the deductible or some~~ other offsetting device of that kind is also built into the program.

MR. LARIMER. The challenges to the actuary involved in individual health insurance are many. As members of the Society of Actuaries we are in a much better position in terms of having a broad knowledge of insuring concepts. One challenge is to borrow and adapt these concepts to apply to the individual medical line. We can use our mathematical skills and creativity to design and analyze varied methods that might solve some of the problems previously discussed.

As a corporate officer I must also be concerned with carrying out our corporate mission, which in shortened form is that we seek to insure a large and broad segment of the population and enable them to get high quality medical care. One segment that we must consider as part of the corporate mission is the individual market, which cannot obtain insurance as easily as the group market. As a corporate officer I must also be concerned with balancing this goal with other corporate needs. One must be willing to consider new alternatives to meet the problems of the individual market. And as an actuary I think I can suggest solutions that a non-actuary just would not consider.

The challenge to an actuary as a regulator will become much more difficult, as new rating systems are introduced. Some of these new methods will require a much more thorough analysis by a regulator.

One challenge to the regulators is to approach these new concepts with an open mind. Regulators should not be looking just for the bad in a new concept.

In the band rating idea some individuals of course will get higher rates because of the band rating. On the other hand, the goal of the band rating is to keep a greater percentage of the low utilizers in the pool that contribute positively to the pool, and therefore keep the overall rates lower. The positive aspects of any new system must be stressed, and explained as clearly as possible to the insurance department.

Another problem for the actuary as a regulator is explaining to the rest of the insurance department and the state government the problems with allowing only limited rate increases with periodic catch-up. In other words, there will be more deterioration of a pool if rate increases of 20% a year are allowed vs. two semi-annual increases of 10%. And this deterioration is adverse to the long term interests of the public.

On the broad topic of withdrawal from the individual medical market, there are several areas that must be considered.

From the consumer standpoint, the consumer would often times not be able to get coverage elsewhere. One of the key elements that a Blue Cross plan offers to a community is stability of local markets. If this large segment of the population were suddenly not able to have insurance, it would be very disruptive to the local market.

From an insurer's standpoint, it could be a significant loss of membership and also marketplace perception problem on a block withdrawal. If a reentry were planned several years down the road, the hard feelings caused by withdrawal could create hurdles that would be difficult to overcome at reentry time.

Block withdrawal could also be an invitation for government to get involved. At Blue Cross-Blue Shield of Illinois we went to great lengths to roll back the amount of government regulation required for individual medical rate increases. Block withdrawal might throw us back into those days of insurance department skirmishes that we would prefer to forget.

Another aspect about Blue Cross plans is the relationship with the provider community. Offering medical products to a segment of the population that otherwise might not have coverage definitely has an impact toward lowering hospital bad debts. The key relationship with providers has allowed the Illinois Blue Cross-Blue Shield plan to implement containment programs that an insurer without such a relationship would not have been able to develop.

Withdrawing from markets that would adversely impact hospital bad debts could do much damage to the good that has resulted from this unique relationship that Blue Cross has with hospitals.

There are other suggestions to avoid market withdrawal. One is controlling the risk or limiting benefits that can be easily abused. Two that have frequently been discussed are limiting private duty nursing benefits and limiting mental and nervous benefits both on an inpatient and outpatient basis.

Another suggestion is to take detailed steps to analyze claim experience by area. There are extremely large variations in medical costs by area. If such area differentials are not recognized there will be either a gradual or dramatic shift in exposures toward the high cost areas which drive up the rate increases and provide a steady stream of losses.

In summary, the individual medical market is full of pitfalls, but it is my belief that creative solutions can be found to allow insurers to continue to serve this important segment of the population.

MR. BLUHM. I want to ask Paul one question, and then consider questions from the audience. All three of the panelists have been focusing on cumulative anti-selection and anti-select lapsation. What are your thoughts on handling these problems through a pre-funding of premium rates?

MR. BARNHART. I am in favor of attempting to do that. Bill is working with a subcommittee of the Society's Health Section; I am working with a subcommittee of the American Academy, and we are hoping to work together on this and come up with a positive specific proposal to recommend to the NAIC. The idea is that pre-funding would be set aside within each company writing the general class of business affected by this, a little bit like a high-risk pool, to be used to pre-fund closed blocks of policies which are caught up in this anti-select deterioration cycle that we have been talking about. All the business of the class concerned would be contributing to the fund. For example, this could be put into effect by allocating three to five percent of premiums on newly issued business, which the insurer would be allowed to consider as part of his loss ratio. These funds would then be drawn upon later to subsidize closed blocks so that people who have been insured for 10 or 15 or 20 years, have some help, some subsidy.

If we accomplish our goal and the NAIC adopts this, it would be a mandatory type of fund, an extra reserve, that would operate specifically for the purpose of subsidizing deteriorating closed blocks. I think it would be very worthwhile, and in the public interest, if we can come up with something that looks like it will help materially. Again, I do not think it is going to be a solution but it is something that can soften the problem and at least be of some help.

MR. ROBERT C. NUDING. I thought all of the suggestions were very imaginative, but I have one specific question. Mr. Larimer, if I understood you correctly, you were thinking of imposing a band rating scheme on existing pools. Don't you have a legal problem introducing a bigger increase for unhealthy individuals on the basis of their own experience? I like the idea prospectively, where they know in advance that that's a possibility, but how do you overcome any legal barriers to do it on existing pools or did I misunderstand you?

MR. LARIMER. No you did not misunderstand me, we are planning to do this to the existing pool. Our individual contracts outside of the Chicago Metropolitan Area are block cancellable. In theory, we could cancel the whole block, and then invite enrollment into the new pool where we could institute this new mechanism. We have not proposed this to the Illinois Insurance Department yet, and that would be one of our more interesting projects in the upcoming year. I plan to let them know much in advance about our thought on this question, so that we do not surprise them at the last minute and give them deadlines that we are up against.

MR. BARNHART. This idea has been discussed informally with Larry Gorski, the actuary of the Illinois Insurance Department, and he does not appear to have objections from an actuarial standpoint. Conceivably, there might be a legal problem.

I want to point out that people tend to view this as reunderwriting, and defining new subgroups within an original existing pool. I think what we have to recognize is that if we do not do this, the underwriting characteristics of the pool are changing anyway. The problem is the pool is deteriorating and becoming more anti-select. These people are not members of some kind of constant underwriting pool. The anti-select lapsation is changing that pool, and therefore, by introducing this rating of the existing pool and encouraging the healthy lives to stay, the healthy lives would still be subsidizing the unhealthy lives. So I think the effect of this is really helpful to the unhealthy members in the pool in the long run, even though they could be getting some upward rate adjustments within the scale that Charlie was talking about. If you do not do anything, the whole pool just goes more and more anti-select and we have seen that happen.

I happen to be the consultant to the association in question that represents the consumer, and their board is strongly in favor of this because they have seen the anti-selection drive the rates for this pool to unaffordable levels; to some of the members on the board this is their last hope. They hope this will work and that it may prove to be a way of saving what is simply becoming an unmanageable pool of anti-select survivors.

MR. BLUHM. I would point out that I have also been recommending a similar thing for use with multiple employer trusts who undergo the same sort of anti-select lapsation, and there are similar regulatory problems with that in some states that limit experience rating on small groups. Are there any other questions?

MR. BRIAN R. LAU. I will make a couple of short comments. First concerning the banding, I hope you go ahead and try it, because I would like to see something work. I am not terribly encouraged, because I think what will happen is you will just isolate the impaired lives even more in a higher rating class. I do not know if you will be able to give big enough discounts to the healthy lives to keep them.

Secondly, on the increasing deductible, I would again like to see it tried. We might be willing to try it ourselves, but I can not be too encouraged, because the insureds will perceive this as both a rate increase and a reduction in benefits.

Thirdly, on the question of a long term projection level premium concept, I would like to see it implemented. I am concerned about this method because of the substantial pre-funding required in long term projections, which would call for cash values. Perhaps universal major medical policies might be what is called for.

MR. BARNHART. As far as trying to index the deductible, I would like to mention that this is being tried, and has been tried. There are several contracts on the market; I think maybe the one Noel is talking about is one example. I believe that Mutual of Omaha and Bankers Life and Casualty have programs on the market involving some indexing of deductibles. The group that Charlie talked about is the Illinois Health Improvement Association, the downstate version of the Blue Cross direct-pay block of people. The deteriorating portion of this group is the under 65 group. What happened was that in 1982 a number of changes had to be made in the rating structure, and some people had enormous rate increases; some as high as 270 percent. The pool dropped from about 75,000 subscribers with dependents down to, currently, about 30,000. We have been using this concept of indexing deductibles for two years now, and it seems to be helping substantially.

The program comes up for either benefit adjustment or rate adjustment every six months. In effect, it is renewal rated every six months. What we have been doing for two years now is when it comes in on January 1st, we have been adjusting the benefits and holding the rates constant, and then on July 1, half-way through that calendar year, it gets a rate increase, so it is a different approach. It is like the 15 percent indexing of both benefits and rates.

The experience has stabilized, the lapse rate has greatly decreased, and the pool, I think, is in relatively better shape. It at least is not continuing to go downhill at such a disastrous level. I mentioned that the board of this organization is very much in favor of the banding that Charlie has described, experience rating banding, if you want to call it that, which is a form of individual experience rating. They cannot wait to see the banding put in place. They are hoping the program will survive through the indexing process long enough to get the experience rating concept working. Everytime we have seen them, they want to know how soon are we going to start doing this. There is one thing that I am afraid of and that is that on third and fourth time around, these deductibles may have to jump so far that it is going to be a problem. The first year the deductible went up from 200 to 300 dollars, the second year it went from 300 to 650 dollars, and even with that kind of a jump, we do not seem to be losing too many of the members. Now the problem is what is going to have to happen next January 1st? Is 650 going to have to go to 1500, or what? So, there is an obvious question; how long can you keep this up before you begin to once again provoke the anti-select deterioration? That is why the group is so anxious to see this band concept put into effect just as soon as possible.

MR. BLUHM. In answer to your thought on people perceiving it as taking benefits away, I had approached a similar situation once in a stop loss policy. Instead of stating the deductible or trigger point as a flat dollar amount, it was expressed as a multiple of expected claims. The multiple did not change even though the dollar amount increased each year. When you index the deductible, if you state it as a multiple of the index amount, I think you have a lot less of a problem of people perceiving that they are having something taken away.

MR. THOMAS J. STOIBER. I would like to comment on the practicality of instituting automatic deductible and coinsurance increases on individual policies. We had seriously considered such an approach in the past and rejected it on the basis that the healthier policyholder could very well be surprised by the lack of benefits his policy actually paid when he did first file a claim, 7 to 10 years from issue. It is not unusual to expect a healthy policyholder with a $500 deductible policy to go that long without a claim given that annual frequency of claims is only around 10% to 12%. The $500 deductible could easily be $2,000 by claim time, and this awakening certainly, without clear regular communication, would encourage the healthy policyholder into lapsation; the very opposite of what we are trying to achieve. Would it not be better to devise a mechanism to encourage the healthy policyholder not to lapse? Someone briefly mentioned a "Universal Life" health policy. Maybe the level premium policy with cash surrender values is more the appropriate answer.

MR. ABKEMEIER. We think an important part of indexing is packaging everything together. When I was using an objective measure such as the CPI, I changed both the deductible and the room benefit limit. The customer can see the bitter and the sweet at the same time, which will help in the acceptance of the package. The policy changes are on his policy page and on the communication letter, so he should be aware of the changes, but it may not hit home until he has a claim.

MR. BLUHM. I am afraid that we have run out of time. I want to thank all the panelists for participating in this session.

E. PAUL BARNHART ◆

FELLOW OF THE SOCIETY OF ACTUARIES
MEMBER OF THE AMERICAN ACADEMY OF ACTUARIES

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July 9, 1985

United States Senate
Committee on Finance
Attention: Ms. Shannon Salmon
Washington, D.C. 20510

Subject: Senate Subcommittee on Health Hearing of June 14:
Response to Questions from Senator Packwood

Dear Shannon:

Enclosed is my response to questions from Senator Packwood, transmitted to me by Edmund J. Mihalski, C.P.A., with a letter dated June 18.

Cordially,

Paul Barnhart

Paul Barnhart

EPB:cg
Enc.

cc: Mr. Gary D. Simms

HEARING of June 14, 1985 concerning
Health Promotion and Disease Prevention Strategies
for Medicare Beneficiaries

Responses to Questions from Senator Packwood
submitted on behalf of the
COMMITTEE ON HEALTH of the
AMERICAN ACADEMY OF ACTUARIES

I am pleased to respond as follows, answering to the best of my knowledge and experience the several questions asked by Senator Packwood in following up on the testimony I submitted at the Hearing of June 14, 1985:

QUESTION 1. Many people are very interested in the dollar consequences of prevention interventions. As has been pointed out, there is an almost total lack of data for the elderly population. Do you have any estimates or opinions of the cost savings in dollar or percent terms:

a. For the five interventions you discussed in your testimony?

b. In general for preventive interventions?

c. For other interventions?

d. For the elderly as opposed to the non-elderly?

A. In response to a., I offer the following estimates and/or opinions with respect to the five interventions discussed. Wherever an estimate is provided, it is in percentage terms. It is true that virtually no credible data actually drawn from the elderly population exists. Most of the actual experience that has been observed with respect to these interventions relates to persons under age 65, and estimates or opinions concerning the impact on the elderly are necessarily extrapolated.

Intervention a. Extension of Coverage to Preventive Expenses.

In this area, there has been no positive evidence, of which I am aware, that such extensions of coverage result in actual cost savings. Instead, they appear to add cost almost to the extent of the value of the added benefits. This is not bad in itself, but the desired offsetting cost savings usually have not been realized.

One reason for this, in my opinion, is that too often the extension of benefits has been too limited to have significant effect: for example, an additional plan benefit of up to $100 or $150 yearly limited to physical checkups and diagnostic services. More comprehensive approaches, such as total care capitation based programs stand a far better chance, I believe, not only to pay for the extended services but also to save money.

Intervention b. Cash or premium refunds to those who do not utilize benefits.

This form of intervention appears clearly to reduce benefit costs, at least on a unit or "per person" basis. One of the important beneficial effects, however, is that of retaining higher participation in a voluntary, competitive program. The presumably "good risks" who have not utilized program benefits are less likely to drop out, expecting their refunds, and this helps to keep unit costs down. But this beneficial objective is not relevant to a mandatory public program such as Medicare, except conceivably to Part B.

There are, however, two other objectives of the refund device:

(1) To encourage participants to avoid seeking unnecessary care or to utilize plan benefits simply because they are available.

(2) To provide some financial incentive toward habits conducive to better health.

In my opinion, Objective (2) tends to be too long-term, and I doubt that this objective has been realized to any significant degree under "refund" plans, although it may play some positive role.

Objective (1), in my opinion, has clearly been realized, under plans with refund features. There is no question but that utilization does reduce. Under some of these programs, where I have had opportunity to observe on-going cost experience, per person cost reductions appear to run 20 to 30% lower than under similar benefit plans without any refund feature. I see no reason why this effect would not still result among elderly participants.

In my testimony, I mentioned one possible negative effect about which I have some concern. This is the suspicion that some participants do not submit claims, or possibly do not obtain medical care, in situations where they should be obtaining care and submitting valid claims under the plan. To the extent this effect may exist, it ultimately runs counter to the objectives sought. I do not know of any program under which this possible effect has been tested or objectively measured in any way, however.

Intervention c. Premium discounts to designated "preferred risks" (e.g., non-smokers).

"Preferred risk" discounts have been in existence for a good many years in the insurance industry. As usually employed, however, they have served mainly as an additional risk classifier at the time coverage is issued. A given applicant either qualifies for the preferred rate or does not. At a later time, he can reapply for the preferred rate, but he must initiate this action himself.

Also, most preferred risk premium structures recognize only a very limited number of specific factors: sometimes only smoking habits. In some cases, additional factors are recognized, such as drinking habits, build and weight, etc.

Because of: (1) the single level of discount (e.g., 10%); (2) the fact that only a limited set of factors are considered; and (3) the fact that the factors considered usually serve only to classify applicants at time of issue, it is my opinion that this device does NOT have any substantial potential for actual cost savings in the on-going operation of a health care plan. Instead, it serves essentially only as an additional risk classifier, in addition to such rating factors as age, sex, occupation and the like.

Intervention d. Renewal premium reclassification, with ongoing cumulative discounts for those with continuing favorable health and claim histories, along with corresponding on-going cumulative premium surcharges to those with continuing adverse claim histories.

This is the approach being taken under the insurance plan of the Illinois Health Improvement Association, to which I referred in the testimony. Unfortunately, this is too new a program for any results or conclusions to have emerged as yet. It was launched January 1 of this year.

It is my own opinion that this program will prove to be relatively effective, especially with respect to Objective (2) mentioned in relation to Intervention b., because the discounts and surcharges are both continuing and cumulative, up to set maximum limits of discount or surcharge. Thus, a favorable risk may earn a 10% discount, then 20% and ultimately 30% as a maximum. The adverse risk may incur a surcharge of 10%, then 20%, etc. up to an ultimate maximum of an 80 or 100% surcharge. Also, they can operate automatically at each renewal anniversary and therefore function as on-going reclassification devices that need not be initiated by participants. Given time, they should therefore provide cumulative and highly visible financial incentives, continually encouraging participants to give on-going attention to improved health habits.

Since we don't as yet have hard evidence of plan experience, I can only say that my opinion here is a matter of expectation and hope: that this program has the potential of realizing substantial cost savings, in the range of 30 to 40% below cost levels in equivalent programs without ongoing, cumulative renewal reclassification. No less need be expected among elderly than among younger participants.

Intervention e. "Total Care" programs, with capitation based premiums.

When Total Care programs are both based on capitation premiums and also provide genuine financial incentive to the providers of care to maintain wellness, rather than to treat illness, these programs can realize, and have realized, substantial cost savings, in the 30 to 50% range.

The evidence is substantial that enormous volumes of unnecessary hospitalization, surgery, diagnostic services and medication occur in the United States. When the financial incentive to the providers is that of minimizing illness services and maximizing wellness services, it easily follows that cost savings are bound to result in the administration of such programs. If these savings can then also be reflected in capitation rate reductions, those who pay for these programs also save.

Again, there is no reason not to expect similar results among the elderly. Cost savings of 30 to 45% are achievable.

B. In response to b. of Question 1, specifically, preventive interventions in general, in my opinion, have the potential of 20 to 25% cost savings. To have any chance of realizing such savings, however, (a) the financial incentives must be real and visible, preferably to both providers and consumers of health care, and (b) the preventive measures and preventive emphasis must be substantial and reasonably comprehensive; not merely token or severely limited in scope.

C. Responding to c. of Question 1, other interventions would include such additional devices as financial incentives directly operating to reduce unnecessary treatment, with such incentives working for both providers and consumers. Here the objective is not preventive care specifically, but rather avoidance of unnecessary care.

The potential here, in my opinion, is another 10 to 25% on top of preventive care intervention; a combined potential of both kinds of intervention of as much as 30 to 50%.

D. Responding to d. of Question 1, in my opinion there is actually greater potential for cost savings among the elderly than among the non-elderly.

There are at least two very major reasons to expect this:

1. The highest costs of course occur among the elderly, and much of this is the cumulative result of poor health habits and practices throughout earlier life. Emphasis on preventive measures and elimination of unnecessary services at ALL ages is ultimately bound to have its maximum cumulative favorable impact among the elderly.

2. Too often, proper care has not been received by elderly Americans, either because of neglect or limited financial resources, or else because it has too often been assumed that virtually all ailments of the elderly are simply the inevitable result of age itself, and that preventive care and even treatment of illness will be futile. More and more evidence is piling up demonstrating that this is just not so.

QUESTION 2. One of the persistent problems that we have had with estimates of the dollar costs and savings of preventive interventions for the elderly is that if the interventions are successful and prolong life, they add costs of care in the additional years of life given by the preventive intervention. Do you feel that such indirect costs should be used in estimating the effect of preventive measures? Are there alternative estimating techniques that do not "charge" these costs to the intervention?

Ultimately all costs of care must be taken into account in some way, whether they occur in earlier or in later years. However, there are a number of considerations that support the expectation that substantial net cost reduction should occur; the costs added later should be significantly less than the costs saved earlier:

1. To the extent that additional years of productive good health and improved quality of life could result from preventive intervention, those extra years can represent an additional period of productive input to the nation's life and economy, rather than a period of financial drain and dependence on others. If later costs of care are to be "charged" against measures of preventive intervention, then additional productive contribution should be credited to that intervention as well.

In this respect, the nation needs to begin thinking of the "senior years" as beginning more in the neighborhood of age 70 or higher, instead of the current general notion of age 65 as the entry. This transition in attitude has already begun. Perhaps we are indebted to some extent to George Burns and Bob Hope for this.

2. Many ailments of the elderly do not so much hasten death as to simply add to the continuing cost of living, because of both the cost of care and the prolongation of invalid, dependence status. More adequate emphasis on preventive care should reduce aggregate costs with respect to this whole class of illnesses, rather than merely deferring it to later years.

3. Thinking in terms of actuarial present value, a dollar of expense incurred five years from now, at, say, 10% interest, is equivalent to only 62 cents today. So even if the costs were the same except for being deferred, let us assume, for 5 years, the savings is still 38%.

Respectfully submitted,
on behalf of the Committee on Health
of the American Academy of Actuaries

E. Paul Barnhart

E. Paul Barnhart

Senator DURENBERGER. Our next panel consists of Christy Bell, the executive director of the Fallon Community Health Plan in Worcester, MA, on behalf of the Group Health Association of America; Jerry Miller, director of Public Relations for the Health Insurance Association of America; Mary Nell Lehnhard, the vice president for Government affairs, Blue Cross and Blue Shield; and Willis Goldbeck, president of the Washington Business Group on Health.

Ladies and gentlemen, your statements will be made part of the record. You are all experienced in this process—most of you, I think, have been here before. You may proceed by summarizing your testimony.

We will start with Christy Bell.

STATEMENT OF CHRISTY W. BELL, EXECUTIVE DIRECTOR, FALLON COMMUNITY HEALTH PLAN, WORCESTER, MA, ON BEHALF OF THE GROUP HEALTH ASSOCIATION OF AMERICA, INC., WASHINGTON, DC

Mr. BELL. Mr. Chairman, I am Christy Bell, executive director of the Fallon Health Plan in Worcester, MA, and I am here today representing the Group Health Association of America, GHHA.

GHHA is the national association of group and staff model health maintenance organizations, HMO's. Our member plans serve nearly 75 percent of the national HMO enrollment. The Fallon Community Health Plan has an enrollment of 63,000 members, including 10,000 of whom are Medicare beneficiaries. Fallon's Senior Plan was the country's first Medicare demonstration project, and on April 1 of this year we became the first of 27 health plans in the country to convert to a Medicare risk contract with HCFA.

We commend you and the subcommittee for your interest in health promotion and disease prevention in the senior population. It is a pleasure for GHAA to present testimony on this issue, because preventive care is an integral component of the HMO system of health care delivery.

As you know, there is a rapidly growing trend of health consciousness in this country. Americans are exercising, adopting more nutritious diets, quitting smoking, moderating alcohol use, and in general developing healthier lifestyles. HMO's encourage and support this trend in view of its very immediate and long-term benefits to their members.

At Fallon we have been actively involved in health promotion and early disease-detection programs since 1977. In 1983 we formalized the health education department through which we provide monthly health education programs, open to the public at no charge, and coordinate daily classes and even one-on-one educational sessions. Our classes on diet, nutrition, and smoking cessation have been especially popular.

Every year Fallon dedicates the month of October to health education and presents several special programs and screenings, including vision testing and blood pressure screenings, to the public. In September of 1983 we presented a program on colon and rectal cancer, including home testing. In some cases major surgery was avoided due to early detection, and polypectomies or minor surgery was all that was necessary. In other cases, major surgery was undertaken, and positive outcomes were achieved due to the timeliness of these procedures. In total, 18 previously asymptomatic persons were treated successfully for colon and rectal cancer via the screening program.

With the growth of our senior plan, we will present other programs specifically geared to that population. We have begun to address the needs of our new members as they join the plan by encouraging them to participate in their own computerized health-risk assessment. Both our regular newsletters and our Senior Spotlight feature information about special programs as well as specific health-promotion and disease-prevention tips. Our weekly aerobic exercise program called Seniorcize is offered for people 65 and over at no charge.

We believe that these programs have had a positive effect on increasing senior citizens' awareness of potential health risks and problems, and promoting ways of preventing them that is improving their overall health status.

There is another significant program in which a GHAA member, Rhode Island Group Health Association or RIGHA, is participating which has relevance to these hearings. RIGHA and the Harvard School of Public Health have received a grant from the John Hartford Foundation to develop a geriatric assessment unit, GAU, to study the unit's impact on treating the complex health and social needs of the elderly. In recent years a number of hospitals and outpatient health care centers have established geriatric assessment units; however, few of the studies have been able to document the effectiveness of such programs in maintaining health and promoting independent living. Some health policy analysts suggest that geriatric assessment units, while expensive to operate, produce health benefits for patients and ultimately reduce health care expenditures by helping to keep the elderly out of the hospital. The RIGHA/Harvard geriatric assessment unit study will address these issues.

Another innovative option for care for the elderly is one in which you, Mr. Chairman, were instrumental, and the HMO industry is grateful for your efforts in ensuring its implementation. That is, of course, the social HMO now being tested in four demonstration sites.

As you know, the social HMO provides Medicare services as well as additional social services and long-term care. Two GHAA member plans are participating in this Social HMO Program—the Kaiser Permanente Medical Care Program in Portland, OR, and Group Health, Inc., in Minneapolis, MI.

In each of the social HMOs there are support services which allow those who might otherwise have to be in a nursing home to stay in their own homes. Services include home health services beyond those covered by Medicare, such as additional nursing care, physical and occupational therapy, and medical social services, support and training for a care-giver in the home, aid with personal care, homemaker services, medical transporation, adult day care, and referrals to community services are also provided. If institutional care is required, additional time in a nursing home or a skilled nursing facility is covered beyond the standard Medicare benefit.

These demonstrations are designed to show that with appropriate coordinated services many elderly individuals may remain in their homes rather than be placed in institutions. This is a more cost-effective approach to long-term care, as well as having a positive psychological effect on individuals.

Again, we appreciate the opportunity to share with you, Mr. Chairman, some of the approaches which HMO's are taking to promote quality of health for their members, especially our senior citizens.

Senator **Durenberger**. Thank you.

Mr. Miller.

[Mr. Bell's written testimony follows:]

STATEMENT
ON BEHALF OF
GROUP HEALTH ASSOCIATION OF AMERICA, INC.

CHRISTY W. BELL
EXECUTIVE DIRECTOR
FALLON COMMUNITY HEALTH PLAN

BEFORE THE
SUBCOMMITTEE ON HEALTH
of the
COMMITTEE ON FINANCE
UNITED STATES SENATE

ON
HEALTH PROMOTION AND DISEASE PREVENTION
STRATEGIES FOR MEDICARE BENEFICIARIES

June 14, 1985

Washington, D.C.

Mr. Chairman and Members of the Subcommittee, I am Christy Bell, Executive Director of Fallon Community Health Plan (FCHP) in Worcester, Massachusetts, and I am here today representing Group Health Association of America, Inc. (GHAA). GHAA is the national association of group and staff model Health Maintenance Organizations (HMOs). Our member plans serve nearly 75% of the national HMO enrollment.

Fallon Community Health Plan has an enrollment of 61,000 members, 10,000 of whom are Medicare beneficiaries. Fallon's Senior Plan was the first Medicare demonstration project in the country designed to test the new Medicare prospective reimbursement system for HMOs, which is now operating under the Tax Equity and Responsibility Act of 1982 (TEFRA).

On April 1, 1985, we became the first of 27 health plans in the country to convert from a demonstration project to a Medicare risk contract with the Health Care Financing Administration (HCFA) to provide Medicare services on a prepaid capitated basis.

Mr. Chairman, I commend you and the Subcommittee for your interest in health promotion and disease prevention in the senior population. It is a great pleasure for GHAA to present testimony on this issue because preventive care is an integral component of the HMO system of health care delivery. Indeed, the very title "health maintenance organization" emphasizes our commitment to protecting the "wellness" of our members. We pride ourselves on comprehensive, high quality, cost effective health care which is attributable in great measure to early detection and treatment of disease resulting in outpatient care or shorter hospitalization.

There is a rapidly growing trend toward health consciousness in this country. Americans are exercising, adopting more nutritious diets, quitting smoking, moderating alcohol use and, in general, developing healthier lifestyles. HMOs encourage this trend and view it as both an immediate and long-term benefit to their members. Good health habits in today's younger population reduce the risks of cancer, heart disease and other degenerative diseases in their older years.

At Fallon, we have been actively involved in a health promotion and early disease detection program since 1977. In 1983, we formalized a health education department, through which we provide monthly health education programs open to the public free of charge. The topics vary from nutrition, exercise, and stress to discussions about specific diseases.

These programs have an average attendance of 350 people with a range of 150 to 600. The largest percentage of attendees are in the 60-69 age group. A flyer describing the program is sent to all subscribers each month and announcements appear in the local newspaper and on the radio. All programs are now being videotaped and can be shown upon request to anyone interested.

We also try to focus attention to particular health subjects promoted as national observances, such as heart disease in February, which is American Heart Month. Every year, Fallon dedicates the month of October to health education and presents several programs and screenings, including vision testing and blood pressure screening, to the public. During the month of October, 1984, we sponsored a road race, encouraging people of all ages to walk, jog, or run for the health of it.

Other topics of health education sessions, while not limited to seniors, are especially relevant to them. They include such subjects as Alzheimer's Disease, age spots and skin cancer, glaucoma and cataracts, hypertension, alcoholism, arthritis, angina, nutrition, vascular and circulatory disorders, stroke, respiratory problems, heart attack, throat cancer, kidney disease, colds, flu, and pneumonia.

In addition to regular semimonthly hypertension screenings, we have conducted special screening projects for colon and rectal cancer and for diabetes. The majority of the participants in these screenings were over the age of 60.

In September 1983, we presented a program on colon and rectal cancer emphasizing the importance of early detection. All members of the Health Plan over the age of 40 were sent home test kits with instructions to complete the test and send it back to the clinic. 16,690 test kits were mailed out and over the next few months we had a response of 2,726 (16%). Members who had positive results were notified and received followup testing.

In five cases, major surgery was avoided due to early detection, and a polypectomy was all that was necessary. In addition to the immeasurable health benefit to those individuals, the cost savings were also significant. In several other cases, major surgery was undertaken and positive outcomes were achieved due to the timeliness of those procedures.

With the growth of the Senior Plan, we will present other programs specifically geared to that population. We have begun to address the needs of our new members as they join the plan by encouraging them to participate in their own computerized health risk assessment. The health educators will go over the printout with each member, identify areas of concern, and help them to plan how to reduce those risks. The new member will also identify a primary care physician at this time and be encouraged to make an appointment for a physical exam if they have not had one within a specified time.

Both our regular newsletters and our "Senior Spotlight" feature information about special programs as well as specific health education tips.

A weekly exercise program called Seniorcize is offered for people 65 and over, provided at no charge to FCHP members.

Participants perform aerobic exercise and learn to take their own pulse.

At Fallon, we believe that these programs have had a positive effect by increasing senior citizens' awareness of potential health risks and problems and ways of preventing them; thus improving their overall health status.

Mr. Chairman, there is another significant program in which a GHAA member, Rhode Island Group Health Association (RIGHA), is participating, which has considerable relevance to these hearings. RIGHA has received a grant from the John Hartford Foundation to develop a Geriatric Assessment Unit (GAU) and study the unit's impact in treating the complex health and social service needs of the elderly. RIGHA and the Harvard School of Public Health are named subcontractors in the grant awarded to the Brigham and Women's Hospital in Boston.

In recent years, a number of hospitals and outpatient health care centers have established Geriatric Assessment Units. However, few studies have been able to document the effectiveness, including cost-effectiveness, of such programs in maintaining health and promoting independent living. Some health policy analysts suggest that GAUs, while expensive to operate, produce health benefits for patients, and ultimately reduce health care expenditures by helping keep the elderly healthy and out of the hospital. The RIGHA-Harvard GAU study, which will address GAU effectiveness and the associated cost issues, should have important implications for the provision of geriatric services at RIGHA and other health care organizations nationwide.

RIGHA's new geriatric unit will be staffed by a team of geriatricians, geriatric nurses, and geriatric social workers. Selected RIGHA members, 65 years and older, will be evaluated and followed in the GAU. Their experience will then be compared to the experience of other RIGHA members, 65 years and older, receiving more traditional forms of treatment.

The comparisons will evaluate three key aspects: 1) what is the overall cost-effectiveness; 2) which patients benefit most; and 3) which interventions, such as changes in medical therapy, homemaker support, and family counseling, are most useful.

This study is expected to develop considerable new data as to the efficacy of GAUs, primarily whether extra expenditures for GAU services are justified by improved health status and lower medical care costs in the long run.

Another innovative option for care for the elderly is one in which you, Mr. Chairman, were instrumental, and the HMO industry is most grateful for your efforts in assuring its implementation. That is, of course, the Social HMO (S/HMO) now being tested in four demonstration sites throughout the country. As you know, the S/HMO provides Medicare services, as well as additional social services and long-term care. The purpose of this experiment is to determine whether a coordinated system of delivery of services to the elderly on a prepaid capitated basis will not only be cost effective but will also improve the health status and quality of life for the elderly.

Two GHAA member plans are participating in the S/HMO program. At the Kaiser Permanente Medical Care Program in Portland, Oregon, Medicare beneficiaries are currently being enrolled in the Medicare Plus II S/HMO demonstration.
In Minneapolis, the Senior Plus Program offered jointly in a risk-sharing venture by Group Health, Inc. and the Ebenezer Society is becoming operational as well. Both demonstrations have a targeted enrollment of 4,000 and are approximately three and one-half year programs.

All of the S/HMO demonstrations will provide Medicare Part A and B coverage plus additional benefits. They will receive prospective reimbursement at 100% of the Adjusted Average Per Capita Cost of Medicare services (AAPCC).

The enrollees pay a monthly premium and minimal copayments for certain services. The benefits include complete hospital coverage, outpatient care, prescription drugs, eye exams and eyeglasses, hearing aids, and extended care benefits. Unique to the S/HMO are support services which allow those who might otherwise have to be in a nursing home to stay in their own homes. The services include home health services beyond those covered by Medicare such as additional nursing care, physical and occupational therapy, speech and language services, and medical social services. Support and training for a caregiver in the home, aid with personal care, homemaker services, medical transportation, adult day-center care and referrals to community services are also provided. If institutional care is required, additional time in a nursing home or skilled nursing facility is covered beyond the standard Medicare benefit.

Enrollees in each of the four demonstrations must complete a health assessment form in order that their health status and need for special services can be determined. This information will also be included in the total data collected on these projects. Following the evaluation, case management can be developed for each individual who requires special support services.

While there is no health screening for enrollment, the demonstrations will reflect the proportion of frail elderly in the population, (estimated at 5-10%). A queuing system may be used to maintain the proper ratio. Both plans will enroll a portion of Medicaid members as well.

These demonstrations are designed to show that with appropriate coordinated services many elderly individuals can remain in their homes rather than be placed in institutions. This is a more cost-effective approach to long-term care, as well as having a positive psychological effect on the individuals.

As an increasing proportion of the American population grows older and lives longer, coupled with a growing concern about containing the cost of health care, it is essential that new efforts be made to keep the elderly healthy and independent as long as possible. Making them aware of ways in which they can take responsibility for improving and enhancing their health status will be of far reaching benefit both to the individuals and their families and to the health care delivery system in general.

Again, we appreciate the opportunity to share with you, Mr. Chairman, some of the approaches which HMOs are taking to promote the quality of the health of our members, especially our senior citizens.

group health association of america, inc.
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July 10, 1985

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James F. Doherty

Mr. Ed Mihalski
Staff Director
Subcommittee on Health
Senate Finance Committee
Room 219, Dirksen Building
Washington, D.C. 20510

Dear Mr. Mihalski:

Christy Bell, Executive Director of Fallon Community Health Plan, who testified on behalf of Group Health Association of America (GHAA) at the June 14, 1985, hearing on health promotion and disease prevention has referred Senator Packwood's follow-up questions to me.

The first question asked us to describe non-elderly related prevention strategies that had been developed by GHAA. As you are aware, GHAA is an association currently representing 137 group and staff model HMOs throughout the country, and, as such, has long been a strong advocate of preventive health care by HMOs. We do not, however, develop specific medical strategies, but rather each individual HMO member plan provides to its members a variety of benefits, including those related to health promotion and disease prevention.

The HMO Act requires that certain basic health services must be offered in order for a health plan to meet federal qualification standards. The preventive health services that are required are immunizations, well-child care, periodic health evaluations for adults, family planning and infertility services, and children's eye and ear examinations. In addition, our member plans provide a number of other preventive services such as pre- and post-natal care, testing for cholesteral levels, mammography, heart rhythm monitoring, adult eye exams and the like.

In response to the question on applying non-elderly related strategies to the elderly, we would point out that most health education and disease prevention activities in HMOs are not limited to certain age groups but are available to all health plan members. However, there are instances where programs can be specifically adapted for the elderly. For example, Mr. Bell noted in his written testimony that Fallon Community Health Plan conducts aerobic excercise classes, called Seniorcize, designed specifically for senior citizens.

We were also asked whether strategies for intervention and prevention differ between the younger and older population. The answer is certainly in the affirmative. The elderly require special attention, particularly in familiarizing them with the HMO health care delivery system and how they can best utilize it. Prevention and intervention for individuals with chronic conditions and/or a number of complex health problems, as is so often the case with the elderly, necessitate additional professional time and resources. Screenings should be conducted more frequently among the elderly to detect potential disease so that preventive measures or early treatment may begin.

As a final note, in our judgment, the best preventive feature of HMOs for all age groups - but especially for the elderly who are on fixed incomes - is the removal of cost as a barrier to health care. Early access to health care is a significant factor in preventing more serious illness at all ages.

Sincerely,

James F. Doherty
Executive Director

STATEMENT BY JERRY MILLER, DIRECTOR OF PUBLIC RELATIONS, HEALTH INSURANCE ASSOCIATION OF AMERICA, WASHINGTON, DC

Mr. MILLER. Mr. Chairman, I am here in place of James Brennan, vice president of Northwestern National Life Insurance Co. in Minneapolis, whose plane unfortunately was grounded in Chicago this morning.

Senator DURENBERGER. Oh, oh. That means I won't get home this noon.

Mr. MILLER. I am director of public relations for the Health Insurance Association of America. The HIAA is a trade association representing some 340 insurance companies.

We have a very deep and growing commitment to disease prevention and health promotion for all Americans. We believe that the best health promotion strategy for Medicare beneficiaries is one that begins long before age 65, the strategy that sets in motion patterns of good health behavior that extend into the older years.

Because of our natural outreach to group policyholders and because insurance companies are themselves large employers, our wellness efforts have particularly emphasized the worksite.

Though cost-containment is an immediate objective of such efforts, it is very clear to us that a byproduct of worksite wellness activities is the pathway they provide to encourage individuals to prepare for a healthy and active old age. One might call it preretirement health planning.

Currently the association is sponsoring the creation of wellness councils, a network of employers across the country organized to promote worksite wellness programs among the local companies in their area.

The wellness council activity has evolved from a series of initiatives by our industry, from an industrywide promotion to encourage smoking cessation to a national video Conference on Worksite Wellness sponsored last year and reaching some 2,000 business and community leaders in some 25 cities.

I might note that several insurance company chief executive officers have recently taken a step to ban smoking on company premises. Smoking cessation is one of the major foci of our industry.

Senator DURENBERGER. That is why I asked the question about HHS earlier. Apparently they are working on it.

Mr. MILLER. An essential purpose of these efforts is to stimulate insurance companies to become more active in wellness for their own employees, group policyholders, and the community at large, and indeed many companies today do sponsor a wide variety of worksite programs.

Dr. Breslow—Professor Breslow—has already referred to the insurance study which some 73 insurance companies and two foundations currently sponsor. It is called the life cycle preventive health services study. It was conceived by an advisory council on education for health and is now in its second phase. As Professor Breslow indicated, it is designed to test the effectiveness of a designated set of preventive care measures for all age groups, from infancy to patients age 75 and over.

Payments for preventive service are being made to three group practice centers with no charge to the study patients. The results of the first phase of the study, completed in 1983, are very encouraging. The patients, according to data collected from two of the study sites, reported significant improvements in health behavior, with fewer patients smoking and more patients exercising, losing weight, and so forth. Indeed, contrary to stereotype, the study demonstrates that elderly patients are willing to change their health habits, in some cases more often than younger adults.

An important part of the evaluation of the life-cycle model is how much it costs, and the data reveal that the average charge is $73 for all age groups; the average charge does increase with age, and reaches $145 per patient visit for adults 60 to 74 years of age.

Also, the study gave no evidence that first-dollar preventive-care benefits will lead to excessive demand for such services.

Currently, as I indicated, the study is in its second 3-year phase. And the purpose of this new phase is to measure longer-term care cost and utilization, and to define the potential effects on health insurance and cost containment.

The life-cycle model is being modified, based on experience, and this includes expanded procedures for elderly age groups. A special effort is being made to follow the high-risk older patients more aggressively in order to change health attitudes and behavior regarding their health status. More attention will also be paid to identifying the functional independence of these patients. Here it is recognized that traditional medical care will not be able to eliminate the chronic conditions so prevalent among the aged. And in creating functional independence, the ability to tend to one's personal needs is the critical element.

Let me comment just for a moment on the nonsmoker discount. Currently, over 100 insurance companies offer nonsmoker discounts under individual life insurance policies. Also, more and more insurers are building fitness incentives in the form of premium discounts into both their life and health insurance policies for people who practice good habits. Future incentives may well focus on hypertension. Insurance companies have already redefined normal blood pressures, reflecting a growing recognition that diet change, weight control, and regular exercise will reduce the risk of high blood pressure and may lead to significant medical cost savings.

Let me say we are also very deeply involved with alternative delivery systems—HMO's and PPO's—and we think that these systems provide many opportunities for preventive care services.

We thank you, Mr. Chairman, and the committee for this opportunity to speak here today.

Senator **Durenberger**. Thank you.

Mary Nell.

[Mr. Miller's written testimony follows:]

STATEMENT OF THE

HEALTH INSURANCE ASSOCIATION OF AMERICA

HEALTH PROMOTION INITIATIVES

OF THE

HEALTH INSURANCE INDUSTRY

PRESENTED BY

JAMES R. BRENNAN

BEFORE THE

SUBCOMMITTEE ON HEALTH

SENATE FINANCE COMMITTEE

UNITED STATES SENATE

JUNE 14, 1985

My name is James R. Brennan. I am Vice President, Group Marketing, for the Northwestern National Life Insurance Company. I also serve as Chairman of the Health Education Committee of the Health Insurance Association of America -- the HIAA -- a trade association representing some 340 health insurance companies.

The HIAA and its member companies have a deep and growing commitment to disease prevention and health promotion for all Americans.

Because of our natural outreach to group policyholders, and because insurance companies are themselves large employers, our wellness efforts have particularly emphasized the worksite. Indeed these programs are viewed as one element of an overall strategy to deal with the problem of still rising, still threatening health care costs.

It is very clear to us, however, that a by-product of worksite wellness activities is the pathway they provide to encourage individuals to prepare for a healthy and active old age. One might call it "pre-retirement health planning".

We believe that no employer, as a responsible citizen of our society, should lose sight of this goal, even though the most immediate objectives for a company to sponsor wellness activities of various types -- from smoking cessation and nutrition education to hypertension control and stress management -- may be to reduce absenteeism, cut overtime, improve productivity, and reduce health insurance claim costs.

It is in this context that I wish to first review for your Subcommittee recent initiatives which have been undertaken on an industrywide level, and by companies individually, to encourage wellness activities among the nation's work force who are, of course, tomorrow's retirees.

Following this summary, I will describe a major commitment we have made to promoting and evaluating preventive health services -- and the financing of these services -- for patients of all ages.

Finally, I would like to comment on individual company incentives, such as premium differentials, to encourage more healthful lifestyles among policyholders as well as touch on alternative delivery systems and how they will impact on health promotion.

INDUSTRYWIDE PROGRAMS

Turning first to our industrywide worksite wellness efforts, I want to tell you a little bit about a new program being put in place at this very moment.

It is being sponsored by the HIAA and involves the creation of a network of Wellness Councils in cities across the country.

The intent is to model these organizations after an actual Council in Omaha, Nebraska -- The Wellness Council of the Midlands -- where over 100 employers have banded together to serve as a catalyst and clearinghouse of information and support for health promotion programs at the worksite.

It is an exciting prospect to envision the Omaha Council replicated in other cities where private initiative can be put to work to improve health practices and reduce the social and economic toll of illness and disability in the community.

The industry goal in 1985 is to establish model Wellness Councils in at least five cities, and I am pleased to report that we are already very close to that goal.

This new effort grows out of the interest and enthusiasm the HIAA engendered last year with the sponsorship of a national video teleconference on wellness, which originated at the Department of Health and Human Services in Washington and was transmitted by satellite to 2,000 business and community leaders in 25 cities.

Both President Reagan and the Secretary of Health and Human Services participated in the teleconference, and the bringing together in each community of so many interested parties was really the spark that ignited our Wellness Council initiative.

In addition, our industry -- along with the life insurance industry -- has undertaken an educational program to assist our member companies and their group policyholders in planning and implementing smoking cessation programs. And we have launched a "Wellness at the School Worksite" program to encourage improved health habits among teachers who might then serve as role models for their students.

These more recent activities have evolved from a series of earlier initiatives, beginning with the creation in 1978 of an Advisory Council on Education for Health. Comprising eminent authorities in the health field, the Advisory Council has as its purpose to recommend priorities for unique contributions the health and life insurance industry can make to help improve the health of the nation. Indeed, just yesterday the Advisory Council met to consider, among other matters, how the problems of aging might be established as a health promotion priority for insurers.

In 1980, the HIAA and American Council of Life Insurance jointly sponsored an insurance industry Conference on Health Education and Promotion. That same year the HIAA commissioned a study on worksite wellness programs and their economic impact by Dr. Charles Berry, the former chief physician to the U.S. Space Program. The study report has been widely distributed within the business community.

In 1983, the HIAA produced a videotape entitled "Wellness at the Worksite: The Time is Now", coupled with a guidebook, which were designed to stimulate interest by corporate chief executive officers in initiating or expanding wellness activities for their work force.

INDIVIDUAL COMPANY PROGRAMS

An essential purpose of all of these efforts is to stimulate HIAA member companies to become more active in "wellness" for their own employees, group policyholders, and community groups. This is clearly paying off. Many insurance companies today sponsor a wide variety of worksite programs. Some programs are comprehensive, others limited in scope. Among the more popular activities for both younger and older workers are smoking cessation, exercise, weight control, alcohol and drug abuse control, hypertension control, heart attack risk reduction, cardiopulmonary resuscitation (CPR), cancer risk reduction, stress management, and accident risk reduction.

Insurance companies are also marketing health promotion packages to assist employers to set up wellness programs. In addition, insurers are involved in community programs, such as health fairs, "run for your life" contests, blood pressure screening, and other initiatives.

My own company, Northwestern National Life's commitment to a healthy lifestyle is long-standing. We have demonstrated our concern for good health by adopting a comprehensive wellness program, by supporting health-related activities in our community and within the insurance industry, and in marketing a wellness program to group insurance clients. To further strengthen our support of good health habits, we are taking a major new step by establishing a smoke-free environment at our company beginning January 1, 1986.

LIFECYCLE STUDY

This brings me to the major undertaking I want to describe in some detail. It is called the "Lifecycle Preventive Health Services Study".

It was conceived by the Advisory Council on Education for Health and is under the aegis of a nonprofit organization called INSURE -- Industrywide Network for Social, Urban and Rural Efforts. Some 72 insurance companies and two major foundations fund the INSURE project.

The purpose of the Study, which got under way in 1980, is to test the effectiveness of a designated set of preventive care measures on all age groups, in short, a lifecycle approach, and, in addition, to see if these techniques can properly be covered by health insurance benefits.

Specifically, the preventive services are tailored to ten age groups.

The latter two age groups are those patients age 60 to 74 and those age 75 and older.

Payments for the preventive services are being made to three group practice centers, with no charge to the Study patients.

These centers are in Appleton, Wisconsin; Danville, Pennsylvania; and Pensacola, Florida.

In addition, work is going forward with the Group Health Cooperative of Puget Sound in the State of Washington to adopt the lifecycle approach to fit an HMO.

The first three years of the Study -- from 1980 to 1983 -- were devoted to finding out whether preventive services, including patient education, can indeed be effectively provided in primary care settings and to see what the specific short-term effects would be.

The selection and timing of services are based on several major studies and include physician and patient education on lifecycle procedures, and forms for data collection.

Part of the initial design included baseline telephone interviews with the Study physicians to determine their attitudes toward prevention ... and the responses should not be surprising and underscore the importance of education.

Most of the physicians -- and bear in mind that this was before the Study got under way -- admitted they got more satisfaction from therapeutic care than preventive care.

They did not feel that they provided preventive care services very effectively and, moreover, that the lack of insurance coverage and reimbursement was a real obstacle to doing more in this area.

The hope of the Lifecycle program was, and is, that these educational and financial barriers can be overcome.

The results of the first phase of the Study -- completed as I indicated in 1983 -- were very encouraging.

The patients, according to data collected from two of the Study sites, reported significant behavioral changes.

Fewer patients were smoking. More patients had begun regular exercise, had lost weight, had cut back on drinking, were using seat belts in their automobiles, and so forth.

What's more, contrary to stereotype, elderly patients were willing to change their health habits ... in some cases, more often than younger adults.

For example, the Study conducted in two sites revealed a higher proportion of smokers 65 years of age who quit smoking (20 percent) than the percentage for all Study adults (18.9 percent).

A higher percentage of the older age group also lost weight, began to use seat belts, and to conduct breast self-examinations.

These results reflect a carefully designed and tested model for preventive geriatric care, as is the case for all other age groups.

It should be noted that for the elderly age groups, the development of a clinical model for prevention poses some special challenges.

Compared to the body of information on which to build a model for the young and middle-aged, the medical literature on preventive services for the elderly remains sparse.

Nevertheless, procedures were developed and special forms prepared to remind physicians what these procedures were in dealing with ambulatory and noninstitutionalized patients from age 60 on up.

These included, in addition to x-ray and lab tests, immunizations, and the like, all of the health promotion techniques that should be applied to reduce risk behavior.

The risk factors for the elderly, of course, are somewhat unique, involving particular attention to accident prevention, especially falls, the use of medication, and the support services that can be provided.

Obviously an important part of the evaluation of the Lifecycle model is how much it costs.

The data reveal that the average cost in charges for the Lifecycle exam, including patient education, was $73 for all age groups at the three Study sites.

This average cost increased with age and reached $140 per patient visit for adults 60 to 74 years of age because of the greater number of lab and x-ray tests.

Equally important is the question of utilization.

If preventive care is a "first dollar covered benefit", will the demand for these services be excessive?

The Study results give no evidence that this would be the case.

The utilization of services was well within normal bounds and totally controllable.

Overall, the first phase of the Study -- the first three years -- indicate that physicians will use the Lifecycle model.

Moreover, they will use it not only on the Study patients, but increasingly the data show they are applying the procedures to their other patients as well ... and in general, the patients, both those who are participating in the Study and those who are not, express satisfaction with the Lifecycle model.

Currently the Study is in its second three-year phase.

The purpose of this new phase is to measure the long-term improvements in health behavior ... to measure longer-term costs and utilization ... and to define the potential effects on health insurance and cost containment.

The Lifecycle model is being modified based on experience, and this includes expanded procedures for elderly age groups.

A special effort is being made to follow the high-risk older patients more aggressively in order to change health attitudes and behavior regarding their health status.

More attention will also be paid to identifying the functional independence of these patients.

Here it is recognized that traditional medical care will not be able to eliminate the chronic conditions so prevalent among the aged ... and that creating functional independence -- the ability to tend to one's personal needs -- is a critical element.

There is today significant evidence that health promotion has the potential to increase such independence among the aged as well as reduce behavioral risk factors.

In general, health promotion for the elderly is moving in the right direction because wellness as a national priority in this country is moving in the right direction.

Our Lifecycle Study clearly indicates that people of all ages respond affirmatively to incentives to modify their high-risk behavior. And they like the idea of preventive care coverage to help pay for such things as preventive checkups.

Indeed, those in our Study expressed a willingness to pay additional premiums for such benefits -- 57 percent said they would pay $5 a month extra to obtain preventive coverage.

Our Study also shows an expressed interest by physicians in providing more preventive care and that they view the lack of insurance reimbursement as one of the major obstacles to practicing prevention.

What this tells us is that preventive care benefits are marketable from the consumer and provider standpoint.

What about from the insurer standpoint?

PREVENTIVE CARE COVERAGES

Traditionally, preventive services were usually excluded from medical care coverage.

However, we see this changing as preventive care more and more comes to be viewed as a cost containment measure or as a trade-off against other types of coverage.

A survey conducted in 1983 by the health and life insurance industry's Center for Corporate Public Involvement revealed that out of 147 responding insurance companies, some 36 companies made preventive care benefits available to group policyholders. Most frequently these were well baby care benefits, but also included physical examinations, vision care, dental care, immunizations, and health risk and stress appraisals.

Currently over 100 insurance companies offer nonsmokers discounts on their individual life insurance policies. Interest in such a benefit can be traced back to 1979 when State Mutual Life Insurance Company released its study on mortality differentials between smokers and nonsmokers. The study indicated that the Company's policyholders who smoked were experiencing a mortality rate almost two-and-a-half times that of their nonsmoking counterparts.

Also, a growing number of insurance companies are building "fitness incentives" in the form of premium discounts into both their life and health insurance policies for people who practice good health habits -- e.g. exercise regularly and maintain proper body weight.

Future incentives may well focus on hypertension. Companies have already redefined "normal" blood pressure, reflecting a growing recognition that diet change, weight control and regular exercise will reduce the risk of high blood pressure and may lead to significant medical cost savings.

In addition, we believe the Lifecycle program and other preventive care activities will merge with cost containment efforts, and this bottom-line approach will be reflected in the benefit plans of the future.

Recently our industry's Advisory Council on Education for Health created a Subcommittee to study the whole question of coverage for preventive health care services. The Subcommittee has developed a model benefit with a schedule of medical examinations and list of various services appropriate to each age group over the entire life cycle.

Currently, this benefit is being refined, and various marketing approaches for preventive care coverages are being explored.

ALTERNATIVE DELIVERY SYSTEMS

Another influence will be the predicted growth of health maintenance organizations.

Experts predict 25 to 30 percent of the population will be enrolled in HMO-type plans by the mid-1990s.

With more and more Medicare patients being treated in the HMO setting -- and with the emphasis these systems place on preventive care -- it is reasonable to assume that health promotion for the elderly will take a giant step forward in the years ahead.

It is also predicted that as Medicare continues to cut its benefits, the market for supplemental private health plans will increase, and this, too, should provide an opportunity to expand preventive care benefits.

Also, there is no reason why preferred provider organizations -- PPOs -- cannot include preventive services in their benefit plans. And, if as the experts predict, PPOs in the future will stress service rather than price, surely their ability to offer preventive care benefits will enhance their marketability and further accelerate the broad coverage of preventive services.

My company, Northwestern National Life, has already introduced this concept to a PPO in the Twin Cities for whom we handle the marketing.

In light of their potential, we view as a most encouraging development the designation of the INSURE project in May of this year as the recipient of a federal grant in the amount of $50,000 to conduct a study on preventive services within a PPO structure. Sponsored under a Cooperative Agreement between the HIAA and the Office of Disease Prevention and Health Promotion of the Department of Health and Human Services, the study has as its objectives:

(1) to stimulate the coverage of preventive service benefits in PPOs;

(2) develop preventive service benefit plans that meet the PPO requirements of marketability and cost containment as well as health effectiveness; and

(3) pilot test the Lifecycle PPO model in an operational PPO working with providers, employers, and carrier administrators.

A second component of the Cooperative Agreement provides for an additional $10,000 to further the efforts of the HIAA Wellness Council program.

FUTURE DIRECTIONS

Because of strong relationships with policyholders and the business community -- and in view of the persistent problem of health care costs -- the insurance industry will continue to expand its efforts to influence health habits among all age groups. Insurance companies are particularly well positioned for a lead role in this area because of expertise in risk factor identification, population profiling, and trend analysis.

Mr. Chairman, let me conclude by stressing the conviction that the best health promotion strategy for Medicare beneficiaries is one that begins long before age 65 ... a strategy that sets in motion patterns of health behavior that extend into the older years. We believe the worksite is very suitable for motivating health behavior change because of the important influence the work setting has on social attitudes and habits not only among workers, but their spouses and children.

Finally, I wish to thank the Subcommittee for the opportunity to present this statement and to assure you that our industry stands ready to cooperate in every appropriate way to help develop strategies to improve the health and well-being of all our citizens, young and old.

STATEMENT BY MARY NELL LEHNHARD, VICE PRESIDENT FOR GOVERNMENT AFFAIRS, THE BLUE CROSS & BLUE SHIELD ASSOCIATION, WASHINGTON, DC

Ms. LEHNHARD. Mr. Chairman, we appreciate the opportunity to review the experiences of various Blue Cross and Blue Shield plans and how they might relate to the Medicare program with respect to three approaches: Financial incentives to encourage healthier lifestyles; second, coverage of preventive services under health benefits plans; and third, broad-based health promotion and education programs. For each of these approaches, I would like to comment on the corresponding bills that you have introduced.

A number of Blue Cross and Blue Shield plans have explored the use of financial incentives and rewards for healthier lifestyles among subscribers. The activities that are encouraged include smoking cessation, weight loss, exercise, and even use of seatbelts. These activities are described in more detail in our statement.

Of particular interest to you would be those plans which take into account a variety of lifestyle characteristics in establishing their premiums. Again, we have provided more detail in our testimony.

One value of these premium reductions for a particular type of lifestyle is that they publicly highlight its importance. We believe this is a major benefit of S. 357. It could also be viewed in another way—as a way to reward, as opposed as a way to encourage, healthier lifestyles. I say this because we think it is questionable whether the financial incentives are sufficient for those people over 65 to quit smoking.

We also believe a major question for the Congress is whether this symbol of support justifies an increase in premiums that would affect all other beneficiaries.

Let me discuss the second point, coverage of preventive services under a health benefit plan. Our own practice, as I think is the practice of most insurers now, is to pay for services primarily intended for the diagnosis and treatment of injury or illness. Preventive services are not within this definition and are not usually covered. Notwithstanding that, we do make coverage for preventive services available to employee groups where employers want that type of protection. We find often, however, that employers are not willing to provide such benefits, because their costs are already high and they have no real assurance that they are going to realize any savings from those group coverages.

S. 358 would not directly provide Medicare coverage for such preventive services; instead, the bill would count beneficiaries' out-of-pocket expenses for such services toward meeting a higher part B deductible.

We believe the major question raised by the bill is whether it is in the best interest of the Medicare Program and its beneficiaries to increase out-of-pocket costs for those who need medical care in order to encourage the use of a wide range of screening and preventive services and hypertension drug therapy. While some individuals will clearly benefit from the greater availability of such services, and while some services are cost effective, we are skeptical about the use of a broadbased approach, and about whether that broadbased approach would produce net savings.

We are also somewhat concerned about the potential administrative costs, of S. 358. Again, we have elaborated on this in our testimony.

As an aside, we would note that, while the greater availability of drug therapy for the treatment of hypertension could undoubtedly avoid much higher medical costs, this is not really a preventive or screening service. Clearly, there are merits to making this type of therapy more available, and we would urge you to question the merits of singling out drug treatment for one disease category when there are others that are probably equally effective and equally needed by beneficiaries.

Senator DURENBERGER. And what are they?

Ms. LEHNHARD. For example, since it is a treatment certainly, cancer drugs, arthritic medications, any type of drug which would stave off a higher-cost more-acute stage of illness.

In the absence of clear evidence that preventive services could provide offsets to the Medicare benefits costs, the Congress may decide it is not reasonable to encourage their use through an increase of the already significant beneficiary cost-sharing requirements. At a minimum, however, we would encourage you to continue your policy of covering as a Medicare services preventive services that have been proven to be cost effective.

We would point out that recent program changes, which you strongly supported, will enable these types of benefits to be made more available without increased cost to beneficiaries of the program. Capitated programs are in an excellent position to offer preventive services to beneficiaries.

Finally, I would comment on health promotion and health education programs. Blue Cross and Blue Shield plans are very actively involved in this type of approach. Plans offer a variety of programs to individual subscribers, groups, HMO enrollees, and the community at large.

Based on our experience, we would certainly support the greater availability of these types of programs for Medicare beneficiaries, and under the bill we would support the effort to justify this broader Federal funding.

I would point out the difficulty, though, in demonstrating, cost effectiveness. Again, the Congress may not be willing to provide funding unless that evidence is very clear.

I would close by going back to note that, if the Congress decides that it cannot provide this additional funding, again I think we have established an excellent mechanism to capitated programs to provide these types of activities through savings.

Senator DURENBERGER. Thank you.

Willis.

(Ms. Lehnhard's written testimony follows:]

TESTIMONY OF THE

BLUE CROSS AND BLUE SHIELD ASSOCIATION

PREVENTION AND
HEALTH PROMOTION
FOR MEDICARE BENEFICIARIES

BEFORE THE
SENATE COMMITTEE ON FINANCE

PRESENTED BY

MARY NELL LEHNHARD
VICE PRESIDENT

JUNE 14, 1985

Mr. Chairman and Members of the Committee, I am Mary Nell Lehnhard, Vice President of the Blue Cross and Blue Shield Association, the national coordinating agency for all Blue Cross and Blue Shield Plans.

We appreciate this opportunity to comment on health promotion and disease prevention strategies for Medicare beneficiaries. Our comments are based on our experiences both as Medicare intermediaries and carriers, and as private health care benefit underwriters. We would like to review Blue Cross and Blue Shield experience and how it might relate to the Medicare population with respect to:

- Financial incentives to encourage healthier lifestyles,
- Coverage of preventive services under health benefits plans, and
- Broad-based health promotion and health education programs.

For each of these issues, we will comment on the corresponding bills introduced by Senator Durenberger and also discuss any major administrative issues related to these bills.

Senator Durenberger has introduced three bills to encourage disease prevention and health promotion for Medicare beneficiaries. The Medicare Part B Premiums Act, S. 357, would raise the Part B monthly premium to $17.60 in calendar 1986, but would reduce this amount by $1 for beneficiaries who certify they are non-smokers. The Part B Prevention Incentive Act, S. 358, would increase the Part B deductible from $75 to $100, indexed in future years by the Consumer Price Index. Out-of-pocket expenses for health screenings, non-covered immunizations, and hypertension prescriptions would contribute toward meeting the deductible. S. 359 would establish Medicare demonstration programs in health promotion and disease prevention. Available programs would include health screening, immunizations, risk appraisals, dietary consultations, stress reduction, exercise counseling and programs, smoking cessation, and prevention of prescription drug misuse.

Financial Incentives to Encourage Healthier Lifestyles

A number of Blue Cross and Blue Shield Plans have explored the use of financial rewards and incentives to encourage healthier lifestyles among their subscribers. Activities that are encouraged include non-smoking, exercise, and even use of seat belts.

Six of our Plans offer non-smoker premium discounts for individual and small group policies. The discounts generally are three to seven percent, but are as high as twenty-two percent in Minnesota for subscribers aged sixty to sixty-four since non-smokers of this age incur substantially lower health costs.

Three Plans, in some cases, take into account a variety of lifestyle characteristics including exercise, drinking, eating and smoking habits in establishing their premiums. One Blue Cross and Blue Shield Plan offers employers a 5% premium discount if they establish an employee health promotion program. One Blue Cross and Blue Shield Plan waives deductible and coinsurance liabilities for subscribers injured in auto accidents if they are wearing safety belts.

One value of these premium reductions is that they are a way to highlight publicly the importance of healthy lifestyles. We believe this is a major benefit of S. 357. It also could be viewed as a way to reward — as opposed to a way to encourage — a healthier lifestyle. We believe it is questionable that financial incentives are sufficient for those over age 65 — or anyone — to quit smoking, particularly if they have been smoking for some time. For example, individuals who now smoke one pack of cigarettes a day already face the prospect of saving over $30 per month — the cost of cigarettes — if they quit.

We also want to mention the possibly major administrative requirements of relating Medicare premiums to behavior patterns. If Medicare wanted to verify the non-smoker status of beneficiaries, this type of activity would be a major new undertaking for the Medicare program, and we believe it would involve major administrative costs.

In summary, because the $1 premium discount is unlikely to encourage many beneficiaries to cease smoking and because of the potential for major new administrative costs, we do not believe that the proposal would result in overall program savings. The value of S. 357 would be as a symbol of support and reward for a healthier lifestyle. On balance, however, we doubt that this symbol justifies the increase in premiums that would affect all beneficiaries under the bill.

Coverage of Preventive Services Under Health Benefit Plans

Our own practice under health benefit programs, as is the practice of nearly all health insurers, is to pay only for services provided in connection with the diagnosis and treatment of illness or injury. Preventive services are not within this definition and are not usually covered. This practice is consistent with the basic principle of insurance which is to spread risks that are unpredictable and difficult for the individual to bear. For insurance purposes, preventive services are regarded as a limited, predictable, budgetable expense, and consequently, not appropriate for coverage.

Notwithstanding that, we do make coverage for preventive services available to employee groups where employers want such coverage. We find, however, that employers are generally unwilling to provide such benefits because their health care costs are already high and there is no assurance that, even if the services are cost-effective in the long run, the savings will accrue to the employer who is currently financing the preventive services. I also would note that there is little conclusive evidence that adding benefit coverage for a broad range of preventive services for adults is cost effective even over time.

S. 358 would not directly provide Medicare coverage for preventive services. Instead, the bill would count a beneficiary's out-of-pocket expenses for such services toward meeting a higher Part B deductible.

We believe the major question raised by S. 358 is whether it is in the best interest of the Medicare program and its beneficiaries to increase out-of-pocket costs for those who need medical care in order to encourage the use of a wide range of screening and preventive services and hypertension drug therapy. While some individuals might benefit from greater availability of such services and particular preventive services — such as certain immunizations — may be cost-effective, we are skeptical that the broad-based approach embodied in the bill would produce net savings from a reduction in the use of medical services. The bill, in effect, recognizes this by increasing the deductible.

We are also concerned that the administrative costs of S. 358 are likely to be major. Our concern is based on the assumption that in applying the cost of preventive services to meet the deductible, all the current requirements of reviewing claims for eligibility of the beneficiary, coverage, and reasonableness of costs and charges would be applied.

The costs associated with these activities would likely be significant and they would have to be balanced against the costs of carrying out current program requirements and the additional program changes likely to be approved for FY 1986.

As an aside, we would note that while drug therapy for the treatment of hypertension can undoubtedly result in the avoidance of much higher medical care costs associated with treatment of severe hypertension, this particular benefit falls in the category of treatment of an existing medical condition. It is not screening or preventive care. There are clearly merits to making drug therapy more available. However, we question the merits of singling out drug treatment for one disease category when others are equally effective and equally needed by beneficiaries.

In the absence of clear evidence that use of preventive services could provide offsets to Medicare benefit costs, the Congress may decide that it is not reasonable to encourage their use through an increase is the already significant beneficiary cost-sharing requirements. At a minimun, however, we would encourage Congress to continue its policy of adding as a Medicare covered service specific preventive services that have been proven to be cost-effective. For example, Congress has approved Medicare coverage for pneumococcal and hepatitis vaccine.

Finally, we would point out that recent program changes — which were strongly supported by Senator Durenberger — will enable these types of benefits to be made more available without increased costs to beneficiaries or the program. Capitated programs are in an excellent position to offer preventive services to Medicare beneficiaries. Medicare HMO and competitive medical plan (CMP) at-risk contracts provide that capitated AAPCC payments which exceed the organizations "adjusted community rate" can be used to enhance the Medicare benefit package. Eight Blue Cross and Blue Shield Plans HMOs now enroll Medicare beneficiaries under capitated arrangements. These Plan HMO's offer various preventive services to Medicare beneficiaries including routine eye and ear exams, immunizations and allergy testing, generally without any copayment. HHS estimates that 400,000 to 800,000 additional beneficiaries will enroll with HMOs and CMPs during the next few years. We believe that provision of new services, particularly preventive services, through this mechanism offers the advantages of avoiding additional costs to beneficiaries or to the Medicare program and providing incentives for beneficiaries to accept the idea of a system which efficiently manages their care.

Health Promotion and Health Education Programs

Blue Cross and Blue Shield Plans are strongly oriented to offering health promotion and health education programs - a third major approach to promoting good health. Of the three approaches discussed today, we are most involved with these activities.

Most Plans offer a variety of prevention and promotion programs to individual subscribers, to particular employee groups, to HMO enrollees, and to the community at large. These programs include those geared to senior citizens such as special exercise programs and materials, and education about appropriate use of prescription drugs. Other initiatives include health screenings, nutrition counseling, smoking-cessation courses and stress reduction education. We would stress that such programs are generally provided separately from the basic health benefits package, often without a separate charge. Also, many of these programs are offered as a community service. Our Plans develop these programs by working closely with employers and community groups at the local level. This enables these programs to be targeted to certain population segments or types of behaviors.

While there is considerable research on the effects and cost-effectiveness of various health promotion programs, the findings are not consistent. Some types of programs are effective while others are not. Even within categories of programs there are usually not consistent results. Much of the information is anecdotal rather than sound research. Therefore, we cannot make any generalization about the cost-effectiveness of this approach. Such programs do, however, publicize the importance of healthy behaviors.

S. 359 would provide for demonstration programs to evaluate the effectiveness of health promotion and prevention activities for Medicare beneficiaries. We certainly would support greater availability of the type of programs specified by the bill and would support efforts to justify their broader federal funding.. However, as noted, it is very difficult to ascertain the cost-effectiveness of these sort of programs, and the difficulty of constructing such demonstration programs should not be underestimated. And, unless the demonstration programs clearly established cost-effectiveness, budget constraints could preclude these programs from being routinely paid for by Medicare.

If Congress determines that there are not sufficient funds to support even these demonstration programs, we believe Medicare HMOs and CMPs — just as in the case of preventive services — can play a major role in increasing the availability of such services. These entities are group settings that can more easily organize and administer effective, targeted programs. Importantly, the availability of health promotion and education would serve as an inducement for beneficiaries to enroll in these at-risk entities that have the potential for long-run savings of Medicare funds.

Summary

In summary, we commend the Chairman for the innovative and varied approaches embodied in this legislative package. Our comments on the bills are as follows:

- We believe that use of a premium discount in Part B premiums for nonsmokers in S. 357 has value as a signal of the importance of a healthy lifestyle, although it is questionable that this value justifies the increase in premiums for all beneficiaries. In addition the discount is unlikely to encourage beneficiaries to quit smoking and there are likely to be major new administrative costs.

- With respect to S. 358, we question whether administrative costs involved and the inconclusive evidence on the cost effectiveness of most preventive services justify the proposed significant increase in beneficiary cost-sharing.

- Demonstration programs provided for under S. 359 to evaluate the cost effectiveness of health promotion and prevention activities are appropriate and may well justify broader federal support of these programs for the elderly. However, because of continuing budget pressures, any demonstration program should be constructed to demonstrate clearly overall savings to Medicare.

Again, we appreciate this opportunity to share experiences and to comment on the feasibility of expanding disease prevention and health promotion programs to the Medicare population.

Blue Cross
and
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July 11, 1985

Edmund J. Mihalski, C.P.A.
Deputy Chief of Staff
for Health Policy
United States Senate
Committee on Finance
Washington, D.C. 20510

Dear Mr. Mihalski:

Thank you for your letter of June 18, 1985. Enclosed is our response to your follow-up questions for the record.

We appreciate your continued interest in this issue. Please let me know if we can be of further assistance.

Sincerely yours,

Mary Nell Lehnhard
Vice President

MNL:am

Enclosure

cc: Ms. Shannon Salmon

Question 1

Ms. Lehnhard, you suggest that inclusion of a $1 premium discount is not likely to encourage many beneficiaries to stop smoking and may incur additional administrative costs under Medicare. I assume that the Blue Cross and Blue Shield plans which offer non-smoker premium discounts verify whether an individual is, in fact a non-smoker. What are the administrative costs associated with that effort? Would you suggest that a larger non-smoker discount is a better approach?

Answer

In our testimony we indicated our belief that major administrative costs would be incurred if Medicare wanted to verify non-smoker status. None of the Blue Cross and Blue Shield Plans which offer non-smoker premium discounts verify whether an individual is in fact a non-smoker. Medicare clearly could adopt a similar ~~approval~~ approach and avoid the administrative cost of verification.

In our testimony on health promotion we observed that a $12 annual discount from the Part B premium for non-smokers would not act as a powerful incentive to quit. The existing incentive — the annual costs of purchasing cigarettes — is substantially higher and seems to have little effect. Probably there is some amount that would act as an incentive to quit for most ~~olderly~~ elderly smokers, but we do not know what that amount would be. Presumably it is greater than the entire propcsed $212.20 Part B premium.

Question 2

Your testimony encourages Congress to continue its policy of adding, as a Medicare covered service, specific preventive services that have proven to be cost effective. Other than pneumococcal and hepatitis vaccinations, what other services would you include?

Answer

As we suggested in our testimony, once a specific preventive service is shown to be cost-effective, we would encourage adding it as a Medicare covered service. We aren't aware of any other services definitely shown to be cost effective for the Medicare beneficiary population.

STATEMENT BY WILLIS B. GOLDBECK, PRESIDENT, WASHINGTON BUSINESS GROUP ON HEALTH, WASHINGTON, DC

Mr. GOLDBECK. It is a great pleasure to be here at the U.S. Senate addressing the issue of prevention, finally. There is absolutely no question that the provision of preventive services for the elderly is appropriate. If we are serious about a national commitment to improving longevity, to improving the quality of life, that we then are also committed to prevention. To do otherwise would simply be publicly contradictory.

The potential savings are a benefit of attempting to achieve that national goal. They are not the national goal—the savings are not the national goal in their own right.

As you have heard from other witnesses, employers are indeed moving, although still far too slowly. But there is progress. The employers in our organization have created an Institute on Aging that, among other things, is dealing with prevention. We are in the process of developing an international foundation for prevention research, in conjunction with the Pasteur Institute in France of ITS in Geneva.

The public and private sectors have to march in comparable directions on these kinds of policies. Medicare must be a participant. We really have no choice, whether the issue is considered from the economic standpoint, where everybody really is sort of discovering the obvious, or the demographic or the increasing amount of evidence of the value of prevention from studies far too numerous to elucidate in this brief moment.

Certainly there are questions—questions about victim blaming, questions about attempting to do everything for everyone, as though all the elderly were a group, when in fact they are not at all. The vast majority of Medicare participants use virtually none of the benefits in any given year. We cannot decide that we should not provide prevention for Medicare benefits because everybody might not use it equally. How contrary that would be.

There are special problems that raise a particular challenge to this concept. Osteoporosis, for instance, is something you cannot address by providing physician services to women only when they are over 70. On the other hand, if we start early enough, you can predict major reductions in this illness. The challenge that implies for Medicare is whether or not to take clearly provable prevention-oriented steps from which it will benefit, but not for a long time.

There are a number of things we could recommend. Certainly you should go ahead and experiment with a whole variety of incentive-related methodologies pertaining to more health education, and prevention. The tax deduction limit on life insurance could be changed; for instance, instead of a flat $50,000, one could decide that for those life insurance plans that provided financial support for preventive services, they could have $55,000 and others would only have $45,000—neutral to the Government, and clearly beneficial as a stimulant, and merely one of the many approaches one could take to tinker with the current financial structures and tax structures.

If Medicare is going to be serious about prevention, we need an Associate Administrator for HCFA for Prevention. This Nation in part functions by symbol. Prevention must be prominant to be taken seriously.

Senator **Durenberger**. Is that your news release today?

Mr. **Goldbeck**. Not mine, no, sir. I suspect there could be a few applicants; we might even have some physicians apply in this day and age, which would be a striking change. [Laughter.]

But if you are going to go about the demonstration approach, which we also would heartily endorse, let us encourage you to take one of two paths: Either make one of those five demonstrations specific for testing the mental health preventive services, or require that mental health preventive services be somewhere in all five; but don't let any form of a competitive or selective process lead us to five demonstrations without mental health preventive services. Let's have your leadership be directed at that which is risky and uncertain, not that which is already known and ought to have been done long ago.

There should be no Medicare freeze for immunization—an utterly absurd economic as well as health policy, and a direct contradiction of the needs for prevention for the elderly, where there is a need for a great increase in influenza-related immunizations.

There can be requirements for providers as well as economic incentives for the beneficiaries. Medi-gap policies, for instance, could be required to offer preventive services or not be eligible for approval by State insurance laws.

And certainly the Federal Government needs to support far more research in this field than it has in the past. One need only look at the tiny budgets of OHPDP, NCHSR, et cetera. And add to that the fact that we are still using the 1977 data from the national medical expenditures study, which is not even scheduled to be repeated. Health policy for the late 1980's should not be based on such a weak statistical base.

Let me close by noting that something is better than nothing. Don't let all of the talk about doing everything correctly stop you from doing something well. Surely we know that the best approach is a comprehensive one, involving base lines and the full panoply of preventive services of which health promotion and education are just one or two. But something is certainly better than nothing. We have traditionally ignored the opportunity of prevention for the excesses of ignorance. Let's not perpetuate that problem out of fear that the concept might work or that our initial effect may be less than perfect.

To fund, to support prevention for the elderly in America is not simply to tinker with the existing Medicare Program; it is to make a statement about our culture, and a very positive statement that we have long lacked.

Thank you very much.

Senator DURENBERGER. Thank you all very much.

[Mr. Goldbeck's written testimony follows:]

Washington Business Group on Health

Health Promotion for the Elderly:
A Merger of Necessity & Opportunity

to

Senate Finance Committee

United States Senate

by

Willis B. Goldbeck

President

Washington Business Group on Health

June 14, 1985

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Executive Summary

From the perspective of the large, national employers which comprise the WBGH membership, there are numerous compelling reasons for the advantages of health promotion to be extended to the elderly.

1. Demographic: The elderly represent the fastest growing segment of our population. Longevity research suggests that this trend will continue.

2. Economic: Currently, the elderly consume far more medical resources than do the young or middle aged. This fact, combined with the demographics and the need to reduce medical care cost escalation, compels us to invest in prevention.

3. Scientific: With each passing year, more studies accumulate showing the positive impact that improved life styles, screening and preventive medicine have upon the elderly.

4. Federalism: In our country, responsibility for the health of the elderly is shared by individuals, families, employers, and local, state and federal governments. Individuals and employers are rapidly discovering the need for and value of preventive services for the elderly. As the largest single purchaser of medical care services for the elderly, it is only reasonable that Medicare make an appropriate investment in health, in prevention and in the improved quality of life which can result from health promotion.

Providing economic incentives, through Medicare, for the elderly to adopt preventive measures is a good concept but applicable only in those cases where the cause, effect and behavior change are clearly identifiable. Smoking is the paramount example. The same type of incentives would be far more difficult to apply to fitness, for example. All purchasers, public and private, must be careful that well meaning incentives do not become damaging penalties for those addicted to a life time of behavior only recently identified as harmful.

However, the concept of economic incentives need not be limited to beneficiaries. Medicare can require all participating providers to offer prevention services.

We also strongly support the demonstrations proposed by Senator Durenberger.

Finally, we need to debunk a few myths. First, the idea that prevention will be too costly because it may help people live longer thus consuming more Social Security and retirement benefits. Aside from being a contemptible attitude, this "position" actually expresses only the fear that prevention may actually work, thus underscoring our skewed priorities. Second, the counter concept that it is "too late" for the elderly to benefit from prevention. This, too, is in error. Studies consistently show the amazing degree to which our bodies recover from years of self-destructive behavior when given the opportunity through health promotion activities. Further, people of 65, for whom health promotion may have actually been "too late" in 1966, are now living 20-30 years. For all reasons, from pragmatic budgeting to human kindness, our society must invest in making those years be productive and marked by rejuvenation rather than avoidable deterioration.

Third, we must not draw the boundaries of prevention for the elderly to exclude that most challenging of all man's technology: the brain. When Medicare became law we knew little about the body-mind relationship; little about the devastation of grieving, of depression among the elderly, of Alzheimer's disease, of substance abuse among the elderly, of cancer remission by guided imagery ... the list is very long and demanding of serious exploration. Just as the social support systems are an essential component of any true health strategy, so too are emotional support systems a necessary component of any prevention strategy ... for any age.

There is a fourth myth: prevention for the elderly should, if acceptable at all, begin with the elderly. This simply defies both the logic and the science inherent in prevention. Take the bone determination illness, Osteoporosis. It can only be prevented by the right combination of diet and exercise during women's younger years. If we really want prevention to be a viable tool for reduced waste and improved health among our elderly, we must finally accept the fact that this is a lifetime need, not a program to be added after age 65. Medicare needs to be a participant, not be mistakenly viewed as the solution.

In urging Medicare to do more, I am acutely aware of the historical failings of the private sector to invest in prevention. As an organization, the WBGH is committed to helping an ever expanding network of employers bring a broad range of prevention programs and screening to all age groups, including retirees.

PREVENTION FOR THE ELDERLY

My name is Willis Goldbeck, President of the Washington Business Group on Health. After ten years of frequent testimony on a seemingly endless -- and often repetitious -- list of medical issues, it is a special pleasure and honor to be asked to speak with you about prevention.

On the surface, there are many questions to be addressed today. All are, I'm sure, important. However, no answers will be of lasting value until we reach agreement on a basic principle: we want to expand both the quality and quantity (i.e., longevity) of life for our elderly.

To question the validity and acceptance of this seemingly obvious statement of public values is anything but frivilous. As an advocate of increased public and private investment in prevention, I am frequently challenged on the basis that such an investment, if prevention is successful, will lead to the undesirable result of increased Social Security and pension costs. Others have suggested that our advocacy for employer prevention programs is misplaced because employees may move to another company or retire thus depriving the company which financed the prevention effort of the benefit it is supposedly due.

There are other reasons to feel uncertain about our commitment and to wonder about the inconsistency of federal policy. In the same session that Congress held its first hearings to express concern for retiree medical benefits, Congress also removed the one effective stimulation for pre-funding those benefits: VEBAs. All of the attention to drunk driving has resulted in beneficial public awareness yet you still allow cars to be sold without automatic seat belts, liquor and wine to be sold without declaration of contents, and advertising of alcohol to continue under the guise of education for product differentiation rather than being recognized for the blatant inducement to excess drinking that it really is. As we hassle over warning labels for cigarettes, we continue to waste tax dollars subsidizing the growth of this killer product and are even considering reducing the taxes on the cigarettes themselves.

The list is almost endless, yet the point is simple: unless we have a broad commitment, supported with public and private policy and budgetary decisions, granting incentives to Medicare beneficiaries will have minimal impact.

Fortunately, we see signs of progress and the historical lack of attention to prevention for elders should not be construed as representative of on-going or scientifically based opposition.

As an organization comprised of the nation's largest employers, we are supportive of providing incentives for elders to have and use prevention services. For Congress to cause such a development is entirely appropriate. Our member companies are steadily increasing their prevention programs in general and specifically for older workers and retirees. Increasingly, these companies understand that they are in a financial partnership with Medicare, one in which both partners need policies toward the common objective of a less wasteful and more affordable care system.

The evaluations of prevention programs, from employer settings to large public studies, consistently demonstrate the value of prevention in terms of macro measures like mobidity and mortality; employer concerns like absenteeism and productivity; economic measures like reduced hospitalization and substance abuse; and micro measures like reduced fire insurance and increased personal satisfaction.

Screening for high risk populations has been clearly established as a valuable prevention mechanism. Aside from the cancers and cardiovascular problems that are discovered in time for intervention, other medical problems, such as hypertension, glaucoma, and elevated glucose are subject to preventive interventions that can save vast quantities of money in the long run. The fact that the vendors of some screening programs fail to provide the necessary medical follow up should not be held against screening itself.

Programs designed to provide information to make elders better consumers of medical care can also be considered to have a prevention orientation. Every unnecessary test, extra day of hospitalization, excess surgery and X-ray, is not only wasted money but also increased risk of iatrogenic diseases and nosocomical infection. Equally important is the fact that these wasted resources are themselves a barrier to the provision of the medical, hospital and long term care that is truely needed.

EVOLUTION

The increase in attention to prevention for the elderly is not by chance. This is one more element of the evolution of prevention and its delivery technology.

Elderly persons have been faced with several serious barriers to the provision of good prevention services.

1. Society believed it was "too late" for prevention to be of value for those who were already in their later years.

2. The medical profession largely ignored prevention and made older people increasingly dependent upon a virtually incomprehensible array of marginally useful medical and institutional services.

3. Those insurance programs that pay for medical care for the elderly do not usually pay for preventive services.

4. Other basic issues such as food, shelter, and transportation consume the vast majority of income for many elderly.

5. The economic incentives built into most medical care finance systems discriminate against professionals who would devote time to health education and have actually rewarded the providers who ignore prevention in favor of repeated and expensive treatment.

6. Gerontology, as a professional field, has, until quite recently, devoted minimal resources to developing comprehensive prevention capability. The aging netework of advocacy groups have typically expended their energy on seeking better medical care programs. Prevention has failed to be seen as an equally significant priority for the elderly by the elderly. The new interest of AARP in health promotion is an encouraging sign.

Today, the basic values of prevention are fast becoming ingrained in the fabric of American society. What was thought to be a fad only a few years ago is now a multibillion dollar industry. Every city is virtually blanketed by runners an amazing number whom are 55 and above. Our diet has changed rapidly, although there is still a long way to go, especially on the related issue of weight loss. Smoking is being defeated; teenagers are developing a non-drinking macho; new employees are placing the quality of health promotion programs as a significant factor in job selection. Prevention for the elderly is an inevitable extension of this evolution. I say inevitable because the demographics are compelling, the public demand as measured in opinion surveys is rapidly growing, the need to use every possible means to reduce medical care consumption is clear, and the results of prevention efforts are most encouraging. Studies have shown the elderly respond well to health education with greater rates of compliance and behavioral change than the non-elderly. Reduction of risk is essential for the long term economics of health care in the USA. Those risks are behavioral and environmental and are, therefore, subject to prevention. It is time to act upon what we already know.

CAUTIONS

As with any worthwhile endeavor or public policy, there are risks to consider, cautions to exercise. None should be allowed to stop progress or become an excuse for the classic decision of inaction. However, the effectiveness of a prevention policy and its resulting programmatic implementation will be enhanced if these factors are considered from the start.

1. We know very little about the long term impact of prevention on the elderly for the obvious reason that no society has ever before experienced an elderly population that also lived for a long time!

2. The prevention opportunities for those in their 60's, 70's and 80's today are not the same as will be appropriate for the next cohort of these age groups. Economic penalties which can be imposed on people in their 40's, as a condition of future Medicare participation, cannot ethically be imposed on current beneficiaries. It is not too late to help those who are to improve their life style and thus waste fewer medical resources, but it is too late to exact financial penalties because they did not have the right diet when they were 30, or smoked when 40, etc. To be successful, prevention must provide positive experiences and realistically address conditions as they are, not as we would wish them to be.

3. Prevention services for some diseases, specifically Osteoporosis, must be provided very early in life if the desired impact upon elderly women is to be achieved. This would be an entirely new Medicare service: a program for young, healthy women in the hopes of preventing future problems.

4. A real commitment to prevention means taking risks in areas where further research is essential.

5. Some preventive services for those who are now known as the "old-old" will appear to cross the line between medical and social or custodial. Nutrition, for example, is of no value to a home bound 75 year old as an education program devoid of a delivery mechanism. Home health agencies, nursing homes, and life care centers and their professional staffs will have to learn about prevention. For many, this will be an unparalleled challenge contrary to their entire history and training.

6. The definition of prevention services should not be too narrowly drawn. Alternative cancer reduction therapies, such as visualization, are just as valid prevention research topics as cellular or viral research at NCI. Psychoneuroimmuniology may open more doors to true disease prevention than all of pharmacy to date. Self care preventive services will become increasingly available, yet costly for many in Medicare.

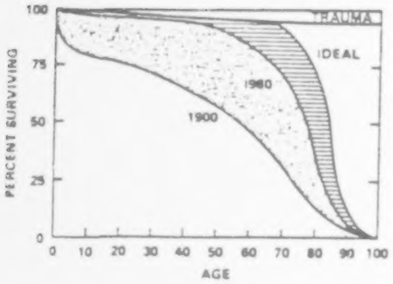
ROLE OF GOVERNMENT

The paramount domestic functions of government are to protect the public health and provide balance among competing interests.

Federal support for prevention would pass both of these tests. What better way to protect public health than to support the prevention of illness and injury?

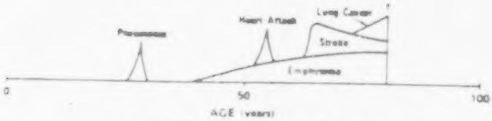
From an economic perspective, supporting prevention is the only option available that may allow us to meet the acute care needs that will be present despite the best efforts of health promotion.

The issue of balance is harder to define in rigid detail, however, noone even slightly convinced of the benefits of prevention can believe that we have a balance between the resources now devoted to curative medicine and those available to prevention. On a national level, the score is roughly 95-5%. In the VA, prevention services are now required but the necessary financial resources not provided. In DHHS, the Office of Health Promotion and Disease Prevention has an annual budget far below ten million dollars. The fact that this office has done a good job with very little is now an excuse for more absurdly low budgets. The time has come to be realistic about the pressures our society will be facing. With no increase in life expectancy, the ratio of those over 65 to those of working age is predicted to rise from 20 in 1980 to 42 in 2030. If that sounds like a long way in the future, please realize that a 25 year old member of the staff of this committee will only be 70 in 2030 and will still be receiving retirement benefits. Of course, there is no reason to believe that we will stop increasing life expectancy. And, if the compression of morbidity so articulately espoused by Fries actually takes place, 70 will not even be considered old. The two graphics on pages 9 and 10 clarify the "squaring the curve" concept and its positive impact upon both quality of life for the elderly and reduced medical expenditures for society. It should also be of interest to note the analysis by Lester Breslow which shows that society spends far less on the medical care during the last year of life of an 87 year old than for a 67 year old. Speaking to a conference of the National Council on Aging, Pearl German of Johns Hopkins stated, "it is sobering to note that about 82% of those 65 and over have not been hospitalized over the previous year -- the figure is 89.6% for the entire population".

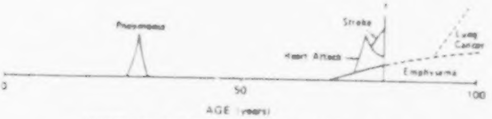


About 80 per cent (stippled area) of the difference between the 1900 curve and the ideal curve (stippled area plus hatched area) had been eliminated by 1980. Trauma is now the dominant cause of death in early life.

Source: James F. Fries, "Aging, Natural Death, and the Compression of Morbidity," New England Journal of Medicine, July 17, 1980, p. 130.



PROTOTYPIC LINGERING CHRONIC ILLNESS



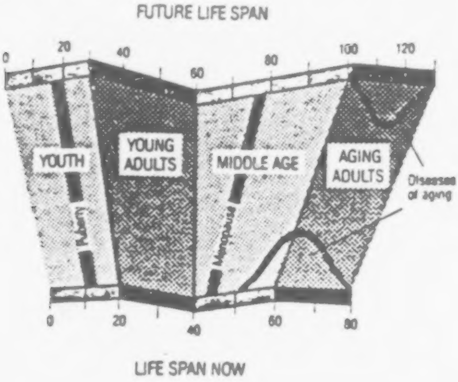
EFFECTS OF THE POSTPONEMENT OF CHRONIC DISEASE

The compression of morbidity The ability to postpone chronic disease, taken together with the biological limit represented by the life span, results in the ability to shorten the period between the clinical onset of chronic disease and the end of life. Infirmity (morbidity) is compressed into a shorter and shorter period near the end of the life span

Source: J.F. Fries and L.M. Crapo, Vitality and Aging, San Francisco: W.H. Freeman, 1981, p. 92.

Another way of looking at the life span issue and potential was presented by Roy Walford in 1983

COMPARISON OF PRESENT AND FUTURE LIFE SPANS

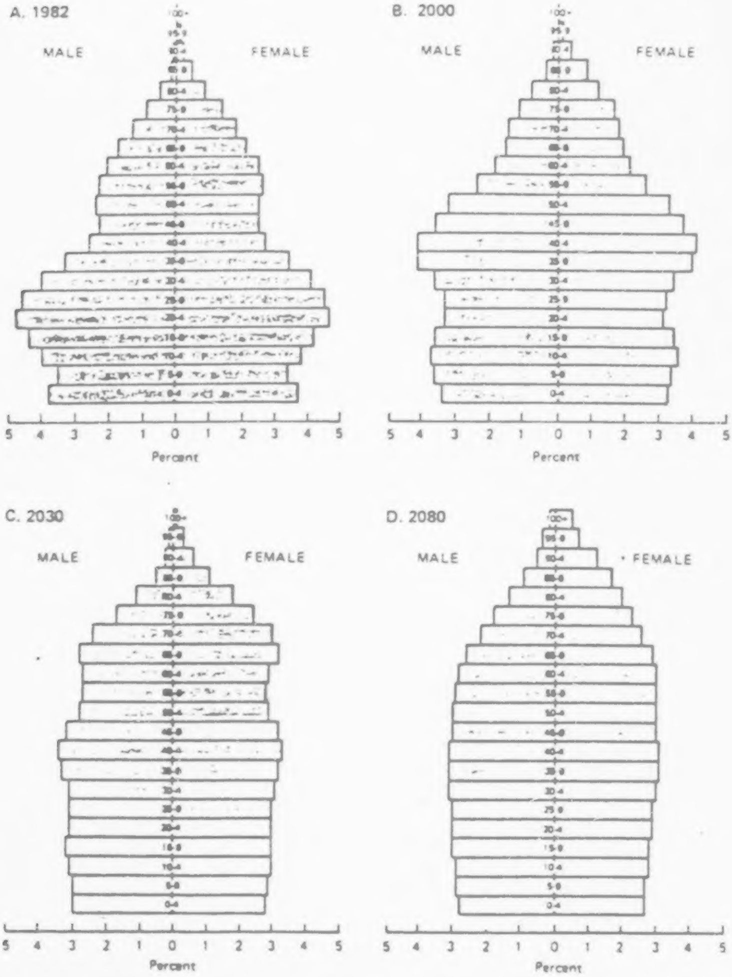

FUTURE LIFE SPAN
0
20
40
60
80
100
120
YOUTH
Puberty
YOUNG ADULTS
MIDDLE AGE
Menopause
AGING ADULTS
Diseases of aging
0
20
40
60
80
LIFE SPAN NOW

Extending maximum life span will stretch out the young-adult and middle-aged periods, probably with less extension of the period of decline. Longer youth period and later menopause will allow greater leeway in family planning. The diseases of old age will be delayed, and exposure to them will cover proportionately fewer years of the life span than they now do.

Source: Roy L. Walford, Maximum Life Span, New York: Avon Books, 1983, p. 190.

If these futuristic concepts are too obscure to be appealing, let me urge that you carefully view the chart below, provided by the Bureau of the Census. If anything, they are conservative yet one cannot miss the drama they represent for our society.

CHANGES IN AGE DISTRIBUTION, 1980-2080



Source: Bureau of the Census, Projections of the Population of the United States, by Age, Sex, and Race: 1983 to 2080, Series P-25, No. 952, Washington: GPO, 1984, p. 5.

Given these conditions and the responsibility we all must share for a new design for a health system for the elderly, we offer a few recommendations for your consideration.

RECOMMENDATIONS

1. Do not be bound by meaningless age-based eligibility criterion. This hearing is, whether one wants to accept it or not, a recognition that age 65 has lost whatever significance it may have once had. The best way to have prevention work for the elderly is to start before becoming elderly. Further, the definition of who is elderly, from a medical consumption standpoint, is rapidly changing. Those over 65 do use much more care, on average, yet 70% of Medicare beneficiaries use less than $600 of care per year.

2. Use the power of tax reform to encourage prevention benefits. There is no social value in having tax reform for its own sake. Each element of the reform should have a clear social purpose. Just as it was appropriate social and economic policy to use tax law for the expansion of private medical insurance, so too is it now appropriate to use tax policy to stimulate the prevention services that we now know will be of value yet lack a natural resource base.

a. Make the provision of prevention services tax free income to employees and families for the next ten years. A defined period and defined set of eligible benefits would provide appropriate stimulation without an open ended commitment.

b. If you consider, as has been discussed, a cap on either all of fringe benefits or specifically on health benefits, exclude prevention services. The goal is to stimulate long term investment rather than short term protection.

c. Life insurance has a natural relationship to prevention for the elderly. Currently, there is a $50,000 limit to the amount of employer provided life insurance which is tax deductible. Why not give an additional $5,000 deduction for those life insurance programs which have a prevention-reimbursement component? For example, if life insurance program A will pay for people over 40 to participate in prevention plans (perhaps $300 per person per year), then employers which contract with that firm could give $55,000 in life insurance while those who contract with a life insurance plan that does not have the prevention reimbursement plan could only give $45,000 of tax free insurance.

3. The decision by Congress to bring preventive services to the elderly can be greatly enhanced by two related actions:

a. Require all Medicare providers to offer preventive services -- you cannot rely only on the economic incentives of DRGs or HMOs...which is proven by the fact that neither hospitals nor HMOs have made more than the most rudimentary steps toward providing these services.

b. Require all Medicare providers to publically disclose their prevention services thus facilitating the ease by which the elderly can shop and compare services and their prices.

4. Do not freeze Medicare/public funds for immunizations. Not only is this an economically as well as medically unjustifiable policy, it is also especially damaging to the elderly who need a greatly expanded program of influenza immunizations.

5. The mental health prevention needs of the elderly are as potentially large a contributor to cost management as their physical health counterparts: the impact of social isolation on increased illness and death; the provision of emotional counseling at the time of major medical care; the recognition of the preventive methods needed to reduce depression among the elderly ... all are as vital to our society as the recent conceptual leap we took senility was divorced from aging and relegated to its proper disease (Alzheimer's) classification. We recommend that one of the demonstration programs in S.359 be dedicated to testing mental health prevention interventions; or that all five demonstrations be required to have a mental health component.

6. Medicare, like its private insurance counterparts, needs to re-evaluate the appropriateness of rehabilitation services for the elderly. Many insurance plans do pay for rehab in a regular hospital but not in a rehab hospital despite ample evidence that the latter produces a much better economic return on investment. With people living so much longer, it will be necessary to design rehab programs for those who previously were expected to accept trauma and disease induced limitations to their independence. Independent functioning is a legitimate measure of prevention success via rehab services.

7. Recognize the non-health yet clearly related factors that are and will be so important to the elderly. For example, the concept of family needs to be replaced by that of household. This is not to denegrate the traditional family, only to accept the fact that its configuration represents a fraction of the homes today and an even smaller share of the households of the elderly. Any combination of supportive adults that can, with minimal assistance, maintain an elderly person outside the institution to which he or she would otherwise be relegated should be considered "family."

Another great need is to use the power of DHHS to influence the priorities of other federal agencies and private research/product developments. For example, the developments of super conductivity may do more to provide heated residencies for the elderly than all government energy subsidies combined. The relationship of a heated home to health maintenance is not hard to understand.

8. For prevention to command the priority, resources and respect it deserves in DHHS, HCFA should create an Assistant Administrator for Prevention, a position of no less import than any other reporting directly to the Administrator. In addition, the budget of OHPDP should be increased as should the evaluative capabilities of NCHSR. The National Medical Expenditure Survey should be immediately refunded and conducted on a regular basis. It is a travesty for federal health policy in 1985 to be set based on 1977 statistics. If the effectiveness of prevention for the elderly is to be evaluated, the commensurate investment in data, health services research and trend analysis must be made.

CONCLUSION

Private sector prevention programs for the elderly will increase and could certainly benefit from carefully constructed federal stimulis, such as those we have tried to suggest.

The public sector, through Medicare, has the option of making prevention the priority it deserves to be. I say deserves not just from a moralistic or even humanistic perspective, but rather from the crass economic perspective that comes from demographics so compelling that one is left with no choice but to seize the promise held by prevention. We can help those who are now old -- and should do so -- but we can virtually save those of us who are the Baby Boomer generation. Saved not from death or even our share of illness and injury. Saved, instead, from the unnecessary deterioration (mental and physical); saved from the annual multi-billion waste on curative medical procedures to correct what would have been quite easily avoided; saved from a value structure that considered aging something to fear rather than to honor and support.

When one reviews the myths and spirituality of other cultures it is hard not to be struck by the consistency with which greatness as measured by economic successes was matched by a reverence for the elders. For the United States, in 1985, to decide to invest in the prevention of illness and injury for our elderly would be more than a prudent economic decision, it would be a statement of our values, a moment to respect and look back upon with favor.

Senator DURENBERGER. I have been looking at a way to characterize my bills, and you gave it to me: Something is better than nothing. Smokers' discount? Yeah, what the heck, we'll add a smokers' discount. You know, increase the deductibility and let people do some prevention things and get a credit against their deductibles for it. What the heck, that's just good logic.

And demonstrations? My God, we've been doing those forever.

So I think something is better than nothing is better than characterizing them as a drop in the bucket, which is what I was thinking of characterizing them as.

But I think by the presence here today of such high quality witnesses that we are at least opening the door by rewarding with public recognition the efforts that a lot of people in the health plan industry as well as other places have been undertaking for some period of time.

We have also found that there is real value in having people speak, as you do in your statement, Willis, debunking the myth that it is hopeless once you get to be such and such an age to work at prevention, or the myth that it is penny wise and pound foolish to keep people living longer because they are just going to cost us more money. And the more that people like you do to dispel these myths, the better it is.

I have tentatively come to the conclusion listening to the testimony so far that we aren't from the Federal side, going to be able to do much more than something's better than nothing. It strikes me—and I want each of you to tell me if I am way off base on this—that the experts from the public health arena talk about treating people as individuals, and don't treat all the elderly as though they are chronically ill. The public health people try to use prevention measures whenever possible. And as I listened to you talk today, I came to the conclusion that those of us in the third-party payment business really will find the answers to these problems in the way we design our health plans. That it is in the design of my benefits, the way I put my Medicare benefits structure together, or the way you do it at Blue Cross, or Fallon, or anywhere where the answer lies. In addition, it's the way the employers insist that these plans be put together, where ultimately we are going to find the more creative, individualized approach to these problems. Now, that is sort of the tentative conclusion I am coming to as I listen to the testimony today.

We can do certain things in the way we structure the financial rewards; but ultimately, it is the way those plans are designed that is going to get the job done.

Does any one of you want to react to that?

Ms. LEHNHARD. I will be glad to respond to that. Our plans are doing just that, trying to see how they can develop a benefit approach that is cost effective.

I would say, however, that they get most excited and think there is the most potential in worksite wellness and health promotion programs, where you really change somebody's lifestyle—the way they eat, whether they exercise, whether they can manage stress. And I am not sure that you can always approach that through fee-for-service payment.

I go back to the capitation programs under Medicare, where you have a population that has a point of organization, and you can sponsor those types of programs more readily because you have a controlled population.

Senator DURENBERGER. But still—and Christy, I hope you will respond to this—you know, I love all the prepaid plans, and the economic notion behind them that is supposed to give them the right incentives to do health promotion. Yet I see a lot of plans trying to sell and sell and sell, and then when they get the patients, they just "move the folks right on through." I don't mean to be derogatory, but where is the wellness and where is the health in these prepaid plans? It's still in the way the plan relates to its individual beneficiaries. You need to set up a certain structure so that "if you do this, then good things happen to you." Are a lot of health plans doing that sort of thing now?

Mr. BELL. My sense is that, first of all, to answer your original question, I think I agree that the assumption of risk or capitation is critical to shift incentives. So if you can shift the risk onto the providers of care, you are going to find them creating more incentives to move into prevention.

Senator DURENBERGER. We all agree on that one, okay?

Mr. BELL. OK.

Senator DURENBERGER. Shift at least part of the risk onto the providers.

Mr. BELL. Yes.

Senator DURENBERGER. OK.

Mr. BELL. But I think that the plans, especially as we see them at Group Health Association of America, there is a tremendous involvement in the health promotion and disease prevention activities. It is inherent in the HMO's, but we probably overlook it sometimes because we are doing it routinely day-by-day and moving patients into programs such as seatbelt programs, buckle-up programs, smoking cessation, et cetera.

Senator DURENBERGER. I want to quit this point because we are running out of time, and my airplane is going to leave, but I said "shift part of the risk onto the provider." Isn't there value, though, in part of that risk being placed onto the consumer? You could have all the employer-based wellness programs you want but, if it doesn't cost the employee something somewhere in that process—to go down to the company gym or eat in the health foods cafeteria, or whatever the case may be—they won't do it. In a group health program or a prepaid plan of some kind, you have to sort of force people. You need to arrange their cost sharing in the system to give them the right incentives.

Have I rambled around this issue so that you can adequately respond to it?

Mr. GOLDBECK. Well, I think your ramblings are on target, in the sense that there is some obvious advantage in having economic incentives on all parties. After accepting that concept, you start to wondering about how much incentive. The idea of a plan that would have a 200-percent economic incentive, as you heard about a little while ago, strikes me as past the tinkering level and probably past the responsible level as well.

From your standpoint, the issue really is not how well some folks are doing with employee plans right now. Yes; there is a major evolution in prevention and wellness in the work setting and through the work setting, hopefully to be including families in the near future. This is marvelous. But that doesn't deal with the direct issues you have responsibility for today. Employer plans are certainly to be encouraged, but they are not the solution for Medicare.

The prepaid industry has struggled its very best to avoid having to deal with a lot of elderly people, much less providing them with a sophisticated prevention package once they have them. And that is also a product of economic incentives and rational economic behavior, so it is not to be disparaged; but it is certainly there.

You see the same problem arise with the new indemnity and other cafeteria, plans, where the groupings are starting to split out into healthy and not healthy. The incentives of prevention should be obvious to any of these private systems. However, You don't see the same degree of prevention applied to older groups in the private sector as you do for younger workers yet. It is starting, but it is not where it needs to be.

It seems to me that your great interest is to use the public's power, economic and political, to stimulate greater amounts of prevention built into the system—not just attached—but real changes in the system, changes in the way providers behave and the way the rest of us behave. You need long-term payoff for groups that are not inherently inbuded with that economic incentive today, and shorter-term payoff for people who are further down the age stream but still, we now know, susceptible to the benefits of prevention. You are not going to find a lot of private sector groups rushing in to figure out how to provide preventive programs to people in their eighth year of Medicare. But we know they still may have 20 more years of Medicare, for which we all must pay and during which the benefits of prevention will be manifest in both economic and quality of life terms.

Senator **Durenberger**. Christy, do you want to defend yourself?

Mr. **Bell**. That is difficult to defend; it is one of the problems we wrestle with. It is a "how to bring the horse to the water" issue. It is how to get the people to take advantage of it. And when you start putting economic barriers between a patient and medical care, you may defeat the purpose of your whole program.

Senator **Durenberger**. Do you mean they will go buy another plan?

Mr. **Bell**. They may. The market may say if you put too much pressure that you have to force them into certain products, they may choose another plan.

Senator **Durenberger**. Well, that's what people worry about with the prepaid.

Mr. **Bell**. Yes; that's the market pressure. And we look at the premium maybe as an encouragement to get them in, and we believe there is in essence a systemwide effort. With the providers, the doctors and nurse-practitioners, and others in the program encouraging the patients on a one-to-one basis, we have had good results. But we haven't found an economic way to force patients into preventive care. Fortunately, the heightened awareness of prevention is bringing people to us that otherwise would have rejected us. The fact that we can institute smoking cessation in the workplace—3 years ago we probably would have lost a half dozen employees. Now, they are leading the way. So I think the awareness factor has helped tremendously.

Senator **Durenberger**. Good.

Mr. **Miller**. I really think the physician may be the key. You can't really force a patient, but experience shows that where the physician has an interest in preventive care, and unfortunately medical education today does not focus on prevention but on cure, where the physician has that interest the patient is more responsive and has confidence in the physician's procedure to encourage the patient to do it. So I really think one key lies in changes in medical education, to put much greater emphasis on prevention and health promotion among the medical profession.

Senator **Durenberger**. You were here earlier when I pointed out the concern that I have that there are ways in a below-the-M.D. professional level that, particularly in a group practice where you can do this kind of education. But if our reimbursement system, or Blue Cross' or somebody else's reimbursement system, doesn't take that into account in some way, then we have created problems for us in the efficient utilization of good professionals who can do this kind of education.

Mr. **Goldbeck**. And by far the fastest way to change medical education is not to ask; it's to change reimbursement.

Senator **Durenberger**. Yes.

Ladies and gentlemen, thank you very much for your testimony. I appreciate it a lot.

Our final panel consists of Ronald E. Fox, the dean of the School of Professional Psychology at Wright State University, Dayton, OH, on behalf of the Association for the Advancement of Psychology; P.T. Alan Jette—I hope I have that correct—associate professor of physical therapy and gerontology at Mass General, on behalf of of the American Physical Therapy Association; Dr. Karl Sussman, professor of medicine at the University of Colorado in Denver, on behalf of the American Diabetes Association; and Dr. Jim Reinertsen from Minneapolis, Park Nicollet Medical Foundation, on behalf of the foundation, I guess.

Gentlemen, thank you very much for being here. You know the ground rules by now. All of your statements will be made part of the record. We will begin with Dr. Fox.

STATEMENT BY RONALD E. FOX, PH.D., DEAN, SCHOOL OF PROFESSIONAL PSYCHOLOGY, WRIGHT STATE UNIVERSITY, DAYTON, OH, ON BEHALF OF THE ASSOCIATION FOR THE ADVANCEMENT OF PSYCHOLOGY AND THE AMERICAN PSYCHOLOGICAL ASSOCIATION, WASHINGTON, DC

Dr. Fox. Thank you, Mr. Chairman. I appreciate the opportunity to appear here today. I will simply summarize the statement that you have.

Let me state at the outset that psychology strongly supports Senate bill 359 and the health-promotion approach for the elderly that it endorses.

As has been said here earlier today, many people mistakenly believe that the elderly are less suitable for prevention programs, and as a result of that belief I think that insufficient attention has been paid to the promotion program and the need for prevention in this population.

Because many promotion programs are directed at people's behavior and attitudes, the fact is that age simply isn't a factor. We advocate fostering preventive activities at an early age, of course, and over the entire lifespan, but prevention programs for smoking cessation, stress, sleeping disorders, depression, and so on, are beneficial to an individual at whatever point they are implemented in their life.

Others have referred to reports that are well known that establish that 7 of the 10 leading causes of death in the United States today are in large part behaviorally determined. It is psychological expertise that is needed to answer the question, how do we change these behaviors and attitudes?

We do have many of the answers already. Behavioral interventions for the elderly in the areas of nutrition, exercise, drug and alcohol use, smoking, and stress can have a significant beneficial effect on the health status of this population. And, as S. 359 recognizes, psychologists and other behavioral scientists should be a part of the health team dedicated to preventing such disabilities.

Several points can be drawn from psychological research. First, the effectiveness of prevention programs seems to depend on their promoting an internal sense of control, fostering self-help behavior and providing options. For example, behavioral research tells us that nursing home residents use less medication when they have control over their own schedules, such as deciding when to eat or sleep or exercise. Second, programs whose major aim is to increase socialization may be limited, inadvertently patronizing, and may divert attention from ways that other people could be genuinely helpful in an older person's life.

Last, programs should be cautious about over-reliance on peer counselors and other paraprofessionals to the exclusion of the appropriate use of professionals who have special knowledge and skills and training in intervention. By directing that prevention programs be based in schools of public health, 359 assures that professional expertise is available for guidance and direction during the course of the projects. We think that is good.

We also know that educational programs for families have increased their knowledge of the aging process. They have resulted in increased use of community resources and services; they have provided some alleviation of emotional strain.

Support groups for relatives of Alzheimers patients are excellent examples, based on the fact that psychological variables may contribute to a less-dramatic decline in the patients. The abuse of the elderly has recently begun to receive attention. Support programs might serve a preventive goal here.

Altogether, we are just beginning to understand the occasions for which support groups are most helpful, and the occasions which call for additional or alternative interventions.

Let me give two examples of how psychological intervention might work in demonstration projects. Two of the most common reasons for nursing home admission are urinary incontinence and broken hips. Both ailments do have some psychological components. At present, urinary incontinence counts for billions of dollars in related costs per year for care, according to the Surgeon General's Report. However, urinary incontinence can be effectively managed through biofeedback, which is a psychological technique aimed at bringing automatic body responses under voluntary control. And broken hips in the elderly, to some extent, can be prevented by teaching the individual how to distribute his or her weight properly when getting into and out of a chair or when walking. You see, an older person generally does not fall down and break a hip; the typical sequence is to misstep, break a hip, and then fall. Behavioral intervention can often prevent this kind of result.

In summary, let me just underline our support for Senate bill 359. As our elderly population grows, and as health costs continue to outpace other economic indicators, it is imperative that we develop preventive strategies to keep the elderly as healthy and active in mind and body as we know how. At the same time, we need to develop techniques which will assure that those who are in need of care receive effective and efficacious treatment. We believe that the demonstration programs envisioned in S. 359 will increase the quality of care for Medicare beneficiaries at reduced cost, and we hope, upon such a showing, that this subcommittee might consider extending coverage for prevention activities to other beneficiaries.

Thank you, Mr. Chairman.

Senator **Durenberger**. Thank you very much.

Dr. Jette?

[The written testimony of Dr. Fox follows:]

American
Psychological
Association

TESTIMONY

of

Ronald E. Fox, Ph.D.
Dean of the School of Professional Psychology
Wright State University
Dayton, Ohio

on behalf of

THE AMERICAN PSYCHOLOGICAL ASSOCIATION

and

THE ASSOCIATION FOR THE ADVANCEMENT OF PSYCHOLOGY

presented to

THE UNITED STATES SENATE FINANCE COMMITTEE
SUBCOMMITTEE ON HEALTH

on the subject of

MEDICARE DEMONSTRATIONS ON HEALTH PROMOTION/DISEASE PREVENTION
June 14, 1985

The Honorable David Durenberger, Chair

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Mister Chairman, members of the Subcommittee, my name is Dr. Ronald Fox. I am a member of the Board of Directors of the American Psychological Association, and the Dean of the School of Professional Psychology at Wright State Univeristy, in Dayton, Ohio. On behalf of the 76,000 members and affiliates of the American Psychological Association, and the Association for the Advancement of Psychology, I am pleased to present testimony on S. 359, a bill to provide for demonstrations in health promotion and disease prevention. Let me state at the outset that we strongly support this bill and the health promotion approach for the elderly it endorses. We feel it is very appropriate that a program whose purpose is to insure against the costs of medical care should promote and sponsor projects aimed at preventing disease and disability and promoting health.

Thousands of health service providers in psychology work with the elderly, and APA is developing curriculum modules to provide special expertise to psychology trainees to work with the elderly. Numbers of psychologists are engaged in basic research in aging, and in applied research designed to improve the delivery of services that will assist the aged to live more comfortable and useful lives.

Many people mistakenly believe that that the elderly are less suitable for prevention programs, and as a result, insufficient attention has been paid to the need for prevention in this growning population. Because many prevention promotion programs are directed at people's behavior and attitudes, age is not a factor. We advocate fostering preventive activities at an early age and over the entire life span, but prevention programs for smoking cessation, stress, sleeping disorders, and depression, for example, are beneficial to an individual at whatever point they may be implemented.

Disease prevention and health promotion programs are not new ideas. The focus of prevention efforts has changed, however. In the early part of this century, infectious diseases were the leading killers in this country. For the health professions and the government, prevention meant innoculation and sanitation programs. Today, infectious diseases are largely controlled. In their place, the leading causes of disability and death have become the chronic conditions such as heart disease, cancer, stroke, and diabetes. These present a new frontier for promotion and prevention efforts. Psychological approaches play a fundamental role in programs designed to prevent such disability.

The 1979 Surgeon General's report Healthy People and the 1982 Institute of Medicine's report Health and Behavior establish that seven of the ten leading causes of death in the United States are in large part behaviorally determined. It is psychological expertise that is needed to answer the question: How do we change behaviors and attitudes? We have many of the answers already, and as S. 359 recognizes, psychologists must be part of the health team dedicated to preventing such disability.

Behavioral interventions for the elderly in the areas of nutrition, exercise, drug and alcohol use, smoking and stress can have a significant beneficial effect on the health status of this population. For example, once the relationship between smoking and a variety of health-related problems was verified, a major effort was launched to change the behavior of Americans. The Public Health Service reports that nearly 40 million people quit smoking which resulted in a marked improvement of the death rates from cardiovascular disease. We are also seeing shifts in dietary habits, exercise patterns, and control of high blood pressure among the general population.

Demographics underscore the importance of the prevention demonstration programs proposed by S. 359. As of 1980, more than 11 percent of the population, almost 26 million people, were aged 65 or older. Incorporating assumptions about longevity, birthrate and mortality, those aged 65 and older will account for a fifth of the total population by the year 2030. What may be more pertinent is to understand that the "oldest old" -- the population aged 85 and older -- will triple between 1980 and 2030. The significance of growth in this group is that these individuals are increasingly vulnerable to physicial ailments, disabilitites, and frailties.

Concern for the health of our citizens as well as for the high cost of health care demand that our federal health insurance program for the elderly be flexible enough to incorporate new, cost-effective treatment approaches that prevent disease and promote health. The close relationship between life-style, behavior and health is unavoidable and the benefits from early intervention that include better health status and the elimination of unneccessary costs is indisputable.

Separating reality from stereotype is a challenge when working with the aged. For example, one of the chief complaints of older persons is difficulties with their memory. These complaints sometimes indicate a legitimate awareness of normal age-related changes and sometimes that the individual is dwelling on these changes and exaggerating them. Memory complaints on the part of the older person are often more indicative of depression than of organic brain change. Educational intervention to help indivduals and relatives recognize and cope with the typical changes associated with aging is useful.

Some negative attitudes have been thought to carry over to professionals and may contribute to patterns of underservice to the aged. Older adults underuse commuity mental health services; they receive only 6 percent of the services rendered -- half what would be expected based on their representation in the population. It is commonly believed that older adults avoid the mental health system but it is important to bear in mind that large numbers of people of all ages avoid the mental health system. Characterizing the aged as a particularly reluctant population may be an instance of blaming the victim. As with all ages, there is ample opportunity for mental health education. At the same time, the reluctance of the aged may well be due in part to their perceptions of the inappropriateness of professionals to their concerns. Older adults, in fact, make heavier use of medical services, due to their more frequent illnesses, yet are less likely than younger adults to be referred by physicians for mental health services.

Numerous programs for the elderly seek to prevent institutionalization and to promote health, independence and a sense of self-worth. Many services that are aimed at preventing or delaying institutionalization are not primarily psychological but have psychological ramifications. It has been shown that too zealous an approach to case management, for example, can result in increased and unnecessary institutionalization by well-intentioned efforts that remove decision making from the older person. Providers must be sensitive to the delicate balance in providing assistance without undermining independence.

Several helpful points can be drawn from gerontology research: (1) the effectiveness of prevention programs seems to depend on their promoting an internal sense of control, fostering self-helping behavior, and providing options (indeed, removing a sense of control from the person may be deliterious); (2) programs whose major aim is to increase socialization may be limited, inadvertantly patronizing, and may divert attention from ways that other people could be genuinely helpful in an older person's life; (3) programs should be cautious about over-reliance on peer counselors and other paraprofessionals, to the exclusion of the appropriate use of professionals who have special knowledge, diagnostic skills, and training in intervention. By directing that prevention programs be based in Schools of Public Health, S. 359 assures that professsional expertise is available for guidance and direction during the course of the projects.

We know that educational programs for families have increased our knowledge of the aging process, have resulted in increased use of community resources and services, and have provided some alleviation of emotional strain. The increased use of services seems not to represent decreased caretaking by the family, but rather a preventive intervention permitting the family to continue its high level of involvement for a longer period of time. Support groups for relatives of Alzheimers patients are excellent examples based on the empirical fact that psychosocial variables may contribute to a less dramatic decline in the patients. Elder abuse has recently begun to receive attention. It is felt that support programs might serve a preventive role. Altogether, we are just beginning to understand the occasions for which support groups are most helpful and the occasions which call for additional or alternative interventions.

To date, results of evaluation research suggest that (1) some positive effects result from prevention intervention, (2) care must be taken not to provide overprotective interventions that may undermine the very independence they seek to promote, and (3) no single intervention is a panacea, rather a variety of options is indicated, reflecting the diversity of the aged population. In terms of funding, it makes sense to imagine a range of programs -- from community empowerment, to case management, to prevention of institutionalization. Further, volunteer and paraprofessional programs (i.e., seniors helping seniors) have a valuable place, used selectively and with adequate training, supervision and professional back-up.

In summary, let me reinterate our support of S. 359. As our elderly population grows and as health care cost continues to outpace other economic indicators, it is imperative that we develop preventive strategies to keep the elderly as healthy and active in mind and body as we know how. At the same time, we must develop techniques which will assure that those who are in need of care receive effective and efficacious treatment. This is our obligation to the nation's elderly whose plea was never more succinctly stated than in Psalms 71:9 "Cast me not off in the time of old age; foresake me not when my strength faileth."

Thank you Mr. Chairman, I will be pleased to respond to any questions you may have.

STATEMENT BY ALAN JETTE, P.T., PH.D., ASSOCIATE PROFESSOR, PHYSICAL THERAPY AND GERONTOLOGY, MASSACHUSETTS GENERAL HOSPITAL, INSTITUTE OF HEALTH PROFESSIONS, BOSTON, MA, ON BEHALF OF THE AMERICAN PHYSICAL THERAPY ASSOCIATION, ALEXANDRIA, VA

Dr. JETTE. Thank you very much, Mr. Chairman. My name is Dr. Alan Jette, and I am pleased to be representing the American Physical Therapy Association at this hearing on health promotion for Medicare beneficiaries.

Our association fully supports the goals expressed in S. 359; but I must add, having sat through the hearing this morning, one does get the feeling of preaching to the converted.

As health professionals who work with patients to maximize functional independence, to relieve pain, and to prevent disability through the use of therapeutic exercise as well as manual and electrical stimulation, the use of modalities such as heat and cold, the goals of this legislation are very consistent with the goals of our profession, physical therapy.

Until quite recently, public policy did not encourage health professionals—and I must say, in my opinion, it still doesn't—to place much emphasis on health promotion or preventive health services for older people. Public policy reflected a belief that the health status of an individual who reaches age 65 is considered fixed; that is, it is felt that not much can be done to improve that person's physical condition at such a late date.

Today, researchers and clinicians are finding that interventions and health promotion measures can make a difference for people in their sixties, their seventies, their eighties, and possibly beyond. We can take osteoporosis as a prime example, a condition which affects between 15 to 20 million Americans. From the age of 30 onward, all of us begin to experience a gradual decline in bone density. At its extreme, osteoporosis, a severe loss of skeletal mass develops leaving the individual highly susceptible to fractures. The risk of developing osteoporosis increases with age and is about four times higher in women than in men. It is estimated that between

25 and 30 percent of women over the age of 65 have some degree of osteoporosis.

A major consequence of osteoporosis is fracture of the hip. The results of such a fracture can be devastating. Fully 20 percent of older people die within 1 year. Research that we are conducting at Massachusetts General Hospital suggests that only 35 percent of hip fracture patients are functioning independently 6 months after the fracture.

The health costs to the Nation related to osteoporosis and related conditions are estimated at a staggering $3.8 billion annually. Although some studies have revealed the benefits of calcium supplementation and other approaches to osteoporosis prevention and treatment, only recently have studies shown that moderate supervised exercise not only slows bone and mineral loss but even can increase bone density. The benefits of exercise in both preventing the onset of osteoporosis and in stabilizing or improving the condition after its onset seems clear. What we don't yet know is if prolonged supervised exercise will have a beneficial impact on reducing the incidence of hip fracture. This legislation could promote such investigation.

The role of exercise in helping to decrease hypertension, as others have mentioned today, is also beginning to be documented. As we are all aware, the result of unchecked hypertension can be a heart attack or a stroke.

Exercise can also be important in stress reduction and in alleviating depression in elderly individuals. Exercise helps to remove the metabolic byproducts of stress, minimizes the response to new stress, and promotes a sense of well-being.

In addition to exercise, techniques such as progressive relaxation, biofeedback, among others, can also be useful in relieving stress.

In general, although research on the impact of exercise for health promotion and disease prevention has been positive, one caveat does exist: Almost all the research conducted on the benefits of exercise has involved subjects who were young or middle-aged, almost always younger than the population served by Medicare.

Some of my own research has highlighted the danger of generalizing from this research to the elderly.

Lack of reimbursement is the major impediment to physical therapists who are interested in researching and promoting such preventive interventions in the elderly. That is why the demonstration projects proposed in S. 359 are so vital. Data from these projects will add immensely to our knowledge about the effectiveness of health promotion and disease prevention strategies among the elderly.

The American Physical Therapy Association believes that these projects, along with the data we in the field will continue to accumulate, will lay the groundwork for the provision of preventive health care services to all our elderly.

Thank you.

Senator **Durenberger**. Thank you very much.

Dr. Sussman.

[Dr. Jette's written testimony follows:]

apta American Physical Therapy Association

TESTIMONY

BEFORE THE
SUBCOMMITTEE ON HEALTH
SENATE FINANCE COMMITTEE

ON
HEALTH PROMOTION/DISEASE PREVENTION
INITIATIVES

PRESENTED BY
ALAN M. JETTE, PT, PH.D.
JUNE 14, 1985

Mr. Chairman, Members of the Subcommittee, my name is Dr. Alan Jette, and I'm very pleased to be representing the American Physical Therapy Association at this hearing on health promotion for Medicare beneficiaries. Our Association fully supports the goals expressed in S. 359.

Before I get into the main part of my testimony, I'd like to just take a minute to explain what a physical therapist does. Physical therapists are trained professionals who work with patients to maximize functional independence, to relieve pain, and to prevent disability. Physical therapists accomplish these goals through the use of therapeutic exercise, as well as manual and electrical muscle stimulation, and the use of modalities such as heat and cold. In fact, the general goals of a plan of care for a geriatric client would be very similar to the goals of a health promotion project: to maintain independent living for as long as possible, to prevent disability or the worsening of a disabling condition, and to allow the individual to attain the highest possible quality of life.

Until quite recently, neither the public nor most health professionals placed much emphasis on health promotion or preventive health services for older people. The health status of an individual who had reached age 65 was considered "fixed"--that is, it was felt that not much could be done to improve a person's physical condition at that late date.

Today, researchers and clinicians are finding that interventions and health promotion measures can make a difference for people in their sixties, seventies, and even eighties. As an example, we can talk about osteoporosis, a condition which affects between 15 - 20 million Americans.

From the age of 30 onward, all of us begin to experience a gradual decline in bone density. At its extreme, osteoporosis, or a severe loss of skeletal mass, develops, leaving the individual highly susceptible to fractures. The risk of developing osteoporosis increases with age, and is about four times higher in women than in men. It is estimated that between 25% and 30% of women over age 65 have some degree of osteoporosis. Among people who live to be age 90, fully 32% of women and 17% of men will suffer a hip fracture, the most common result of a fall. The results of such a fracture can be devastating - 20% of these elderly patients die within a year, from complications and infections due to their immobility. Many of those who do recover remain at least partially disabled, and are consequently at a much higher risk of institutionalization. The health costs to the nation related to osteoporosis are estimated at a staggering $3.8 billion annually.

Numerous studies have indicated the potential benefits provided by calcium supplements in osteoporosis prevention and treatment. Several recent studies have now shown the slowing of bone and mineral loss and even increases in bone density as a result of moderate exercise. One study found that the level of total body calcium increased significantly in a group of women who exercised three times weekly for one year, while calcium levels declined over the same period for a control group. Another study, which utilized elderly nursing home residents, found that bone mineral content increased by 4.2% among a group that exercised three times weekly over a three year period, while declining in the control group.

While more study is needed, the benefits of exercise both in preventing the onset of osteoporosis and in stabilizing or improving the condition after its onset seem clear. One very exciting breakthrough in terms of prevention is the development of a scanner which can detect osteoporosis before physical symptoms are present. A person who is found to be "at risk" can thus begin to treat the condition before it becomes disabling.

Along with increasing bone density, supervised exercise can play an important role in increasing flexiblity and strength and improving posture and gait, all of which are important in decreasing falls and injuries, and in maintaining independence.

The role of exercise in helping to decrease hypertension has been well documented. As we are all aware, the result of unchecked hypertension can be a heart attack or stroke - either of which can be disabling to the individual and extremely costly to treat. When heart disease does occur, the prospects for recovery are much better when hypertension is under control. Similarly, recovery is generally faster from a heart attack or from coronary bypass surgery if a person is in good physical condition.

Exercise can also be an important tool in stress reduction and in alleviating depression in elderly individuals. Exercise helps to remove the metabolic by-products of stress, minimizes the response to new stress, and promotes a sense of well-being. In addition to exercise, techniques such as progressive relaxation and biofeedback can also be useful in relieving stress.

Although in general research findings on the impact of exercise for health promotion/disease prevention have been very positive, one large caveat exists. Almost all of the research conducted on the benefits of exercise has involved subjects who were much younger than the geriatric population served by the Medicare program.

For example, research which I conducted, along with Dr. Laurence Branch, found 5-year mortality rates among a large sample of Massachusetts elderly did not vary according to whether or not an individual exercised regularly, slept between 7-8 hours a night, smoked cigarettes, drank heavily, or ate regular meals. We may well find that while health promotion activities do not impact significantly on mortality, they do compress morbidity--in other words, an individual may remain healthier and more functionally independent longer. The findings of my study point out the danger of generalizing the results of research done on younger populations to a much older age group. In the field of physical therapy, I know that one impediment to clinicians who are interested in researching health promotion interventions has been the lack of reimbursement for such treatment. Much more work needs to be done on the outcomes of health promotion/disease prevention initiatives with elderly people.

That is why the demonstration projects you propose in S. 359 are so vital. Data from these projects will add immensely to our knowledge about the effectiveness of health promotion/disease prevention strategies for the elderly population. Like you, I believe that these projects, along with the data we in the field will continue to accumulate, will lay the groundwork for the provision of preventive health care services to all of our elderly citizens.

STATEMENT BY KARL SUSSMAN, M.D., PROFESSOR OF MEDICINE, UNIVERSITY OF COLORADO MEDICAL SCHOOL, DENVER, CO, ON BEHALF OF THE AMERICAN DIABETES ASSOCIATION, NEW YORK, NY, ACCOMPANIED BY DR. HAROLD RIFKIN, PRESIDENT-ELECT, AMERICAN DIABETES ASSOCIATION

Dr. SUSSMAN. Mr. Chairman, I want to thank you for allowing us to come here. I am Karl Sussman, president of the American Diabetes Association, and with me is the president-elect, Dr. Harold Rifkin. You catch me in one of my last official duties as president, since Dr. Rifkin will be president next week.

Senator DURENBERGER. I am glad I caught you both.

Dr. SUSSMAN. I also want to take this opportunity to thank you for sponsoring Senate Joint Resolution 145, which establishes November as National Diabetes Month.

In this area of health promotion and disease prevention, I think diabetes enjoys a special role. And I notice that we are perhaps one of the only groups that presents as a single disease, and perhaps my presentation will be somewhat different.

We have been focusing on this question for a number of years and have had two conferences which I would like to put into the record. One was a conference at Airlie, VA, on Financing Quality Health Care for Persons with Diabetes. This was held in October 1984. And then we participated in the Carter Center Conference held this past year, in which the Centers for Disease Control presented data relative to the problems of diabetes mellitus in the United States. This data comprised an epidemiologic survey that also outlined preventive strategies.

Senator DURENBERGER. We will make it part of the file of this hearing.

[The information follows:]

Conference on Financing Quality Health Care for Persons with Diabetes

Airlie, Virginia
October 22–24, 1984

Executive Summary

Sponsored by: **American Diabetes Association**
Centers for Disease Control
National Diabetes Advisory Board

Overview

A number of factors affect the quality of health care for persons with diabetes, including the availability, affordability, and extent of insurance coverage for therapeutic services, supplies, and devices considered by experts as essential to achieving and maintaining good glycemic control. Recent advances in diabetes treatment and ways of improving coverage for state-of-the-art care were discussed at a 3-day conference near Washington, D.C.

The conference, which was cosponsored by the American Diabetes Association, the Centers for Disease Control and the National Diabetes Advisory Board, brought together over 125 leaders from the insurance industry, government agencies and the diabetes community, including the heads of the Health Insurance Association of America, the Health Care Financing Administration, and the National Association of Insurance Commissioners. Participants also included representatives from Blue Cross and Blue Shield Associations, the American Medical Association, the Congressional Office of Technology Assessment and individuals from over 35 other organizations.

Three themes were repeatedly expressed throughout the conference. First, therapeutic approaches exist that can substantially reduce the human and economic cost of diabetes. Second, quality diabetes health care and cost containment are not mutually exclusive. To the contrary, quality diabetes care can reduce medical expenditures by averting costly complications such as diabetic blindness, amputations, and kidney failure. Third, ongoing communication is needed between the diabetes community and insurers in order to translate current medical knowledge and future therapeutic advances into improved coverage and outcomes of care.

In his opening presentation, Karl E. Sussman, M.D., President of the American Diabetes Association, stated that an estimated 5.5 million people in the United States are known to have diabetes and there may be an equal number as yet undiagnosed. Diabetes annually costs over 300,000 lives, 25 million hospital days, and nearly $8 billion in direct medical expenditures. Dr. Sussman added that, while a cure does not exist for diabetes, many of its costly complications can be prevented or substantially delayed by effectively applying currently available knowledge in managing and treating diabetes. For example, with improved glycemic control, some 70 percent of the serious congenital malformations associated with overt diabetic pregnancies can be prevented.

Dr. Sussman also noted that with timely eye examinations and appropriate laser photocoagulation therapy, up to 60 percent of diabetic blindness can be prevented. Good foot care, hypertension control, smoking cessation, and glycemic control can reduce amputations in people with diabetes by up to 50 percent. Effective patient education can reduce hospitalizations and emergency room visits by up to 50 percent. Dr. Sussman pointed out, however, that these and other reductions in the human and economic costs of diabetes are dependent upon improved coverage for specific therapeutic services, supplies, and devices.

James L. Moorefield, President of the Health Insurance Association of America, stressed that "communication is the key" to putting state-of-the-art care into general medical practice. Describing insurance as the handmaiden of medicine, Mr. Moorefield went on to say that therapeutic approaches outlined by Dr. Sussman are particularly important in view of spiraling medical costs. According to Mr. Moorefield, it is incumbant upon the diabetes community to get its message across concerning the cost savings which can be achieved by improved coverage.

As evidence that the diabetes community's "message has not been getting through to employers and insurers," Ellen Williamson of Mercer-Meidinger, a large group purchaser, indicated that the health insurance clearinghouse has virtually no information on diabetes. She also stressed the need to get the information cited by Dr. Sussman into the hands of individuals who make coverage decisions by publishing in their trade journals and developing a model benefits package for people with diabetes.

Chrysler Corporation's Director of Employee Benefits, Walter B. Maher, noted that diabetes is the second leading cause of hospitalization among Chrysler employees. Mr. Maher indicated that the health care system "encourages volume and leaves little incentive for cost control, contrary to the law of supply and demand." Chrysler Corporation, he said, must sell 70,000 cars and trucks to pay its health bill, which amounts to over $400 million each year or $550 per vehicle. Because the system has focused on quality and ignored costs, the diabetes community must be prepared to show the projected cost savings as well as therapeutic necessity for specific coverage benefits.

Carolyne Davis, RN, Ph.D., Administrator of the Health Care Financing Administration (HCFA), remarked that her agency expended nearly $150 million in fiscal year 1984 in payments due to diabetes. This sum was exclusive of the costly complications of diabetes, such as amputation and renal dialysis, which are separate cost categories. Noting that 25% of the patients with end-stage renal disease have diabetes, Dr. Davis encouraged Conference participants to find ways of providing "better care at less cost." She also encouraged clustered activities in hospitals so that all hospitals in a community are not doing everything and, thus, offering exactly the same services, i.e., out-patient education programs.

Former Senator and Department of Health and Human Services Secretary Richard Schweiker, a leader in the fight against diabetes since the early 1970's, added that "we have come a long way in a short time in diabetes research, care, and treatment, but we are overdue to begin a dialog on financing issues." Mr. Schweiker, who is President of the American Council of Life Insurance, emphasized the preventive aspects of health care and called for "an informational breakthrough" and "permanent dialog between the diabetes community and reimbursement community."

These and other prominent plenary speakers set the stage for dividing the Conference participants into three topic areas: Access to health insurance coverage for people with diabetes, coverage for diabetes patient education, and coverage for diabetes supplies, devices and new technologies. Following a round of focused presentations and discussions on each topic, the participants were further subdivided into 12 work groups. Although information presented in the three topic areas, including the projected cost savings from specific therapeutic interventions, will be published as a part of the conference proceedings, a brief summary follows for each topic area.

Access to Insurance Coverage for People with Diabetes

Information was presented documenting that lack of health insurance and inadequate coverage are major problems for persons with diabetes. Approximately 5 to 8 percent of all persons with diabetes have no health insurance and this figure is even higher for persons under 65 and other selected groups. Poor health status, high cost, and lack of availability are major reasons for persons not having health insurance. For persons unable either to obtain individual health insurance plans or to be under a group plan, there are few alternatives available. Seven states now offer a pooled-risk plan. These provide comprehensive medical care and hospital coverage to state residents who are unable to obtain coverage in the marketplace. Various public health programs, such as Crippled Children's Services, offer other options, but coverage and eligibility vary from program to program, county to county, and state to state.

The Health Insurance Association of America reported on a survey among 35 private companies, which account for 76 percent of the group health insurance and 33 percent of the individual health insurance business. Of these, 14 companies write basic hospital-medical expense plans for individuals with diabetes and only eight offer major medical policies for persons with diabetes.

In group policies, periodic check-ups, ophthalmic screening for retinopathy, and insulin and oral medication are routinely covered. In individual policies a number of factors including age, duration of diabetes, type and amount of medication and associated complications can affect both the cost (extra premiums for diabetes-related coverage) and extent (waiting periods of 3 to 24 months, exclusion riders for diabetes related coverage) of coverage. Insurance coverage for diabetes seldom covers preventive measures that may reduce complications, medical care utilization, and related costs. For the person with diabetes, not only is access to adequate insurance coverage a problem but total medical care expenses are approximately three times greater than for a person without diabetes.

Coverage for Diabetes Patient Education

It was reported that a review of over 3,600 hospital records of diabetic patients in Pennsylvania produced an average of 31 days per year per diabetic person requiring hospitalization. Similar data in Maine, Michigan, and Rhode Island revealed the need for outpatient education programs. Subsequently, 30 to 50 percent reductions in hospitalizations were achieved among patients who participated in these programs, which were conducted under the direction of the Centers for Disease Control. It was also reported that, although diabetes outpatient education has been proven health effective and cost effective and is an integral component of diabetes treatment, reimbursement for diabetes education is currently fragmented and inconsistent.

Although there is no uniform program design for providing self-care instruction, the need for wider dissemination of existing information about diabetes patient education was stressed. Such information includes standards for diabetes patient education programs, data that have emerged from model programs, and mechanisms for insuring the quality of such programs and qualifications of instructors.

Reimbursement for Supplies, Devices and New Technologies

It was reported that coverage for diabetes supplies, devices, and technologies varies widely among third-party payers. In addition, claims for specific items such as insulin pumps, home blood glucose monitors, and blood testing supplies often are handled on a case-by-case basis.

It was also reported that, except for within the diabetes community, there is a general lack of information about the effectiveness of these devices. The lack of coverage and information is most evident for therapeutic shoes that, along with good foot care, can substantially reduce the number and costs of lower extremity amputations. With over 40,000 diabetic amputations performed each year in the United States, the cost of hospitalizations from this devastating complication exceeds $250 million each year.

Time and again, it was stressed that information about the medical efficacy and cost-effectiveness of health care technologies must be collected and widely disseminated. It was emphasized that the American Diabetes Association should publish the proceedings of the conference in medical journals that are likely to be widely circulated within the insurance industry.

Recommendations

In summary, the conference provided a valuable forum for expressing the views and concerns of the organizations represented, for articulating the health care needs of people with diabetes, and for developing recommendations for closing specific coverage gaps in health insurance.

The recommendations of the Conference were:

1. A Task Force should be established to serve as a forum for ongoing communication and to guide the implementation of the conference recommendations. The Task Force should consist of representatives from the major organizations in the insurance and diabetes communities including, but not limited to, the following organizations that actively participated in the planning of the conference:
   - Health Insurance Association of America
   - Blue Cross and Blue Shield Associations
   - National Association of Insurance Commissioners
   - Group Health Association of America
   - Congressional Office of Technology Assessment
   - American Diabetes Association
   - National Diabetes Advisory Board
   - Centers for Disease Control

   The American Medical Association, the American Association of Diabetes Educators, the Juvenile Diabetes Foundation, the American Dietetic Association and other organizations with interests in the recommendations of the conference should also be asked to participate on the Task Force.

2. The Task Force should coordinate the preparation of an executive summary and a complete report of the Conference on Financing Quality Health Care for Persons with Diabetes. The American Diabetes Association will be responsible for the publication and dissemination of these documents. The executive summary should be published in medical journals that are likely to be widely circulated within the insurance industry.

3. The Task Force should foster the establishment of a central authority for the ongoing collection, analysis, and dissemination of information related to diabetes expenditures, including the cost experiences of insurers and costs related to disease outcomes. The Centers for Disease Control is recommended as the focal point for this activity.

4. The Task Force should establish a panel of experts to develop and periodically update a model benefits package based on the clinical effectiveness and cost effectiveness of specific items discussed at the conference including, but not limited to, patient education, therapeutic shoes, and coverage for supplies and devices needed for self administration of insulin and self blood glucose monitoring.

5. The Task Force should actively pursue and work within existing frameworks for assessing new health care technologies, for seeking coverage for new therapeutic modalities, and for reviewing and identifying obsolete technologies for diabetes. The leadership of the American Diabetes Association should also consider providing funds to the newly established Council on Health Care Technology and become involved in the initial planning of the Council.

6. The Task Force should actively pursue third-party coverage for therapeutic shoes where medically necessary. This effort should include legislation in support of Medicare reimbursement for therapeutic shoes.

7. The Task Force should provide insurers with appropriate information on the effectiveness and necessity of diabetes outpatient education. The communication should include information on the National Standards for Diabetes Patient Education Programs, mechanisms for conferring "recognition" to programs that meet recommended standards for quality, and data that have emerged from model programs including the cost effectiveness and health effectiveness of patient education.

8. The Task Force should actively encourage pooled-risk plans in every state. To ensure equitable funding of these plans, it is further recommended that the National Association of Insurance Commissioners obtain and maintain information on existing pooled-risk plans. Alternative sources of medical care for uninsured or uninsurable persons should also be identified.

9. Development of the following resource materials for consumers and providers was recommended:
   - Information concerning the availability of individual health insurance plans for people with diabetes,
   - Alternative sources of care, including public health programs,
   - How to negotiate with individual insurers for reimbursement of diabetes patient education.

National Standards for Diabetes Patient Education Programs

National Diabetes Advisory Board November 1983

National standards for diabetes patient education programs have been endorsed by the National Diabetes Advisory Board. These standards were developed under the auspices of the Board and in collaboration with the American Association of Diabetes Educators, American Diabetes Association, Centers for Disease Control, Diabetes Research and Training Centers, International Diabetes Center (Minneapolis), Juvenile Diabetes Foundation, and National Diabetes Information Clearinghouse.

This statement presents the rationale for the standards and a plan for their implementation. It includes a summary and description of the standards and a tabular presentation for easy reference.

The Need for National Standards

Major strides have been made in the treatment of diabetes during the last decade as a result of biomedical research, technological advances, and improved application of currently available knowledge and resources. Dramatic increases in our knowledge of effective approaches to prevention of some of the complications of diabetes include better methods to assess and control blood glucose. It is now possible to limit the severity of some long-term effects of the disease and thus reduce its medical, social, and economic impact.

Several barriers, however, still preclude the widespread availability of preventive approaches in self-care. These barriers include lack of patient and provider knowledge about diabetes, inadequate reimbursement policies, and lack of coordination among key components of the health care system. One major impediment has been the lack of national standards to assure that the education provided to people with diabetes is of an acceptable quality and appropriate for the individual.

The National Diabetes Advisory Board, in collaboration with experts from within and outside the diabetes community, has developed national standards for diabetes patient education programs. These standards establish specific parameters against which programs can measure themselves. The standards are rigorous enough to be acceptable to the diabetes community, yet flexible enough to be practical for the primary care community. They are applicable in any health care setting. The Board encourages adoption of these standards by all diabetes patient education programs.

National Plan for Implementation of the Standards

The National Diabetes Advisory Board (NDAB) is mandated by Congress to oversee the Long Range Plan to Combat Diabetes. In addition to its advisory role, the Board has come to serve as a forum through which the diabetes community can focus on common needs and problems and share in their solutions. Through a series of workgroups, the Board and cooperating organizations determined that the availability of the standards would be enhanced by a process to ensure their widespread application. They are therefore developing a national system of recognition for diabetes patient education programs that meet the standards. Recognition is a voluntary process through which programs meeting the standards are formally identified for a level of performance, integrity, and quality entitling them to the confidence of the community they serve. The process is flexible enough to apply to programs that conform to other standards, provided the other standards adhere to the national consensus standards or are modified to do so.

The standards and the recognition process will be pilot tested during 1984 and 1985. Pilot testing will be conducted under the auspices of a Board-appointed steering committee consisting of representatives of the diabetes-related organizations involved with the Board in the development of both the standards and the recognition process. These organizations include the American Association of Diabetes Educators, American Diabetes Association, Centers for Disease Control, Diabetes Research and Training Centers, International Diabetes Center (Minneapolis), Juvenile Diabetes Foundation, and National Diabetes Information Clearinghouse. The results of the pilot testing will form the basis for modifications in the standards and for any required adjustments in the recognition process prior to nationwide implementation. Support materials will be available to provide diabetes patient education programs with additional information on (1) how to meet the standards, (2) how to initiate or upgrade a program to meet them, and (3) how to apply for recognition.

Summary and Description of the Standards

Diabetes is a serious and common disease that is treated directly or indirectly in practically every health care facility in the nation, regardless of size or location.

In chronic diseases, especially diabetes, patients are required to assume a major share of responsibility for their own care. Only an informed and well-motivated person who has the support of the primary health care provider can carry out this responsibility effectively. Evidence is growing that inadequate patient knowledge results in multiple hospital admissions, excessive use of emergency rooms, unnecessary medication, and a high incidence of long-term complications of diabetes, all of which increase human suffering and escalate the costs of care. Studies testing patient education as the variable component of the treatment regimen have shown consistent reductions in these measures. Education for self-care is therefore recognized to be a fundamental component of quality treatment for the individual with diabetes.

At the present time, both the quantity and quality of education offered to people with diabetes vary considerably in the United States. Experience in other fields has demonstrated the ability of uniform standards to improve the quality, effectiveness, and availability of programs. It is hoped that the implementation of national standards will result in increased access to this fundamental component of treatment by stimulating adequate reimbursement for diabetes patient education.

The diabetes patient education standards consist of 10 components that will enable an institution to establish a new program or modify an existing one. Each standard offers the flexibility required to tailor a patient education program to the type of diabetes, its duration, and the life-stage of the diabetic person. Many of the standards are overlapping, reflecting the interdependence among all components of an effective diabetes education program.

1. Needs Assessment. A successful program is the product of a flexible policy based upon the needs of the community it is intended to serve. Since the diabetes caseload varies from one institution to another, each institution should assess its own needs and match its resources to the needs of its caseload. The needs assessment should be performed initially to guide the management of the program and to form the basis for program planning. It should be a continuing process that will allow the program to adapt to changing service requirements. In addition to the needs of the program, the needs of the individual patient should be assessed to provide the basis for the instructional program offered to each patient. The person with diabetes is recognized to be an equal partner in all aspects of the educational process.

2. Planning. Planning is an essential component of a diabetes patient education program. The planning process should describe the program's goals and objectives, target audience, setting (inpatient, outpatient), patient-referral mechanisms, procedures, and evaluation methods. The planning process should be a cooperative effort involving people with diabetes as well as health professionals.

3. Program Management. Effective management is required to implement a patient education program. A variety of health care professionals is involved in the total care of people with diabetes. Clear lines of authority and efficient systems for communication should be established among everyone involved in the program. The ultimate responsibility for all aspects of program management should rest with one person designated as the program coordinator. In addition, an advisory committee should be established to assist the coordinator and other members of the program staff in setting policy and managing the program.

4. Communication and Coordination. Several levels of communication are essential to the effective coordination of the program. Physician leadership and participation are necessary to ensure the integration of patient education into the treatment regimen. A physician should be identified to serve as the liaison between the education program coordinator and the medical staff. In addition, the institution should maintain regular channels of communication with its staff and the community it serves to inform diabetes patients and their families about the availability of the program. All information on the patient's educational experience should be incorporated into the medical record.

5. Patient Access to Teaching. It should be the policy of the institution to facilitate access to patient education for the target audience specified in the plan. This is promoted by a commitment to routinely inform both patients and staff about the availability and benefits of patient self-care programs. Diabetes patient education should be regularly and conveniently accessible, and the instructional program should be able to respond to patient-initiated requests for information. The program permits referral by health professionals, health care agencies, or individual patients. The instructional design encourages active patient participation.

6. Content/Curriculum. The individual patient's needs assessment provides the basis for the instructional program offered to each patient. The assessment should be documented and should include all relevant information regarding the patient's treatment, education, and support systems. Responsibility for various facets of the assessment can be divided among the instructional team members. Curriculum and instructional materials should be appropriate for the specified target audience, taking into consideration the type and duration of diabetes and the age and learning ability of the individual. Both curriculum and available community resources should be reviewed and updated periodically. The institution should provide the program with adequate space, personnel, budget, and materials.

7. Instructor. Qualified personnel are essential to the success of a diabetes patient education program. Each institution should be responsible for identifying and evaluating its instructors. Instructors should be skilled professionals with recent experience and training in both diabetes and educational principles. The number of instructors should be proportional to the caseload requirements. Instructors should be allotted sufficient time to complete the instructional program.

8. Followup. Followup services are important because diabetes requires a lifetime of proper care. The institution should provide followup services that include periodic reassessment of the patient's knowledge and skills and should offer supplementary educational services when warranted. Written communication between the program staff and the primary care physician is essential for ongoing identification of the patient's needs. This is especially appropriate in regard to referral for early diagnosis and treatment of the complications of diabetes. Referral to community resources may also provide ongoing support for long-term psychosocial needs and behavioral modification skills. If a patient changes care settings, the institution should request the patient's permission to send his/her records to the new health care setting.

9. Evaluation. The institution should review the educational program periodically to ascertain that it continues to meet the national standards. This review should be conducted by the advisory committee. The results of this review should be utilized in subsequent program planning and modification. An assessment of each patient's needs and progress should also be conducted at regular intervals.

10. Documentation. Program planning and evaluation should be documented to provide the basis for future program development and modification. All information about the patient's educational experience should be documented in the patient's medical records, as should communication among treatment and education professionals.

National Standards for Diabetes Patient Education Programs

This table presents the standards in a form for easy reference. Standards applicable to the facility offering the program are designated "institution standards" and are separated from those applicable to the education program itself, which are designated "program standards."

	STANDARDS	
	Institution	Program
1 Needs Assessment	• The institution shall assess its diabetic caseload to determine the allocation of personnel and resources to serve the instructional needs of the caseload. • There shall be a reasonable match between caseload requirements and resources allocated.	• An individualized and documented ongoing assessment of needs shall be developed with the patient's participation. This shall include medical history, present health status, previous diabetes education, health services utilization, associated medical conditions or risk factors, diabetes knowledge, skills, attitudes, self-assessment, identification of support system, barriers to learning, and financial status. • The needs assessment shall be the basis for the education program delivered to each patient.
2 Planning	• The institution shall have a written policy that affirms patient education as an integral component of quality diabetes care.	• The participants in planning shall include health professionals involved in the care and education of persons with diabetes and persons with diabetes and their families. • The planning process shall,define (in order): a) Program goals and objectives b) Target audience c) Program setting d) Patient access mechanisms e) Instructional methods f) Resource requirements g) Patient followup mechanisms h) Evaluation
3 Program Management	• A coordinator shall be designated and responsible for all aspects of the program. • The organizational relationships, lines of authority, staffing, and operational policies shall be defined. • A standing advisory committee with both medical and community/consumer representation shall be established.	• Not applicable.
4 Communication/ Coordination	• A physician shall be identified to serve as liaison between the program coordinator and the medical staff. • The institution shall regularly inform its staff and the patients (and potential patients) it serves of the availability of its diabetes patient education program.	• All information about the patient's educational experience shall be permanently incorporated into the patient's (medical) records maintained by the institution. • The role of each education team member shall be clearly defined, and the intercommunication between each shall be documented in the patient's record. • There shall be written evidence of coordination between different care settings.
5 Patient Access to Teaching	• The applicant institution shall have a policy to inform patients routinely about the benefits and availability of patient education.	• The program shall be regularly and conveniently available. • The program shall be responsive to patient-initiated requests for information and/or participation in the program's activities.

COMPONENTS	STANDARDS	
	Institution	Program
6 Content/Curriculum	• The institution shall provide space, personnel, budget, and instructional materials adequate for the program. • Assessment of available community resources shall be performed periodically.	• The program shall be capable of offering information on each of the following content items as needed: a) General facts b) Psychological adjustment c) Family involvement d) Nutrition e) Exercise f) Medications g) Relationship between nutrition/exercise/medication h) Monitoring i) Hyperglycemia and hypoglycemia j) Illness k) Complications (prevent, treat, rehabilitate) l) Hygiene m) Benefits and responsibilities of care n) Use of health care systems o) Community resources • The institution shall specify the mechanism by which the curriculum shall be reviewed, approved, and updated.
7 Instructor	• The institution shall identify appropriate instructional personnel and ascertain their competence. • The numbers of personnel identified shall be suitable for the diabetic caseload within the institution. • Designation of time for identified instructors shall be appropriate to accomplish the necessary educational objectives.	• Instructors (health professionals and others) shall be part of a comprehensive care and education program. • Instructors shall have recent experience and training in diabetes and knowledge and skills in educational principles and their application.
8 Followup	• The institution shall transmit the educational record to other appropriate health care settings when a patient transfers his or her care responsibilities.	• The program shall provide followup services for those patients who wish to maintain continuity of education within the institution. These services shall include: a) Periodic reassessment of knowledge and skills b) Timely reeducation based on reassessment c) Communication with the primary care provider about the need for professional and nonprofessional services.
9 Evaluation	• The institution shall review periodically the performance of the instructional program and ascertain that it continues to meet national standards.	• The program shall conduct and record an individualized assessment of each patient's original needs and progress at regular intervals. • The program shall be reviewed in ongoing fashion for both process and outcome, and the results of this review shall be used in subsequent planning and program modification.
10 Documentation	• All aspects of the evaluation shall be recorded by the sponsoring institution and reviewed periodically to ascertain that national standards are being maintained.	• All aspects of the educational program offered to each patient shall be recorded in that patient's medical record as maintained by the institution.

Dr. SUSSMAN. First, Mr. Chairman, diabetes is a disease in which, when we talk about preventive strategies, we are talking about going from screening and making the diagnosis of diabetes, increasing public awareness of diabetes, and intervening with such measures as obesity control, to simply managing outpatients with diabetes quite well in order to prevent complications and keep them in a state of well-being, keep them as productive citizens within our society, down the line to measures which are specifically taken to treat complications.

One of our major problems in this area is that the health insurance programs which presently exist are not available to a vast number of patients with diabetes mellitus; and furthermore, if they are available, the benefits packages which are presented are not sufficient to promote health promotion and disease prevention in that particular subset of patients. And this is an area which we are currently addressing within our association.

Now, more specifically to the testimony which was turned into the committee, we have 5.5 million diagnosed diabetics; approximately 2.1 million of these patients are over 65. We think that by the year 2010, in which there is going to be a doubling of patients over the age of 70, we are going to see a tremendous increase in the elderly diabetic population. And we at present within our association are considering various strategies which must be implemented in order to serve the special needs of the elderly.

Let me just say in passing that we have the evidence that if patients will lose weight, particularly in the patient population above the age of 40, they can completely prevent the development of diabetes or have much less serious disease even though they may possess the genetic tendency for developing that disease.

As you know, certain complications are prevalent in our diabetic population. For example, these complications are kidney failure, blindness—diabetes is the leading cause of blindness in our country—amputations, heart disease, stroke, and complicated pregnancies. Well, if one can intervene by instituting appropriate control, one can prevent these complications from developing.

But diabetes is a disease which is dependent upon the patient being knowledgeable and engaging in certain self behavior in order to do the things which are necessary for promoting well-being. Patient education and nutritional counseling is an integral part of what we do. In three States, for example, it has been shown—in Michigan, Rhode Island, and Maine—that just simply by the institution of patient education programs you could decrease the rate of hospitalization by 50 percent.

Similarly, if one provides laser therapy in the treatment of diabetic retinopathy before it leads to total blindness, one can reduce visual loss by 60 percent.

We are standing in the position in the field of diabetes where we have the evidence that the measures that we are talking about in terms of health promotion and disease prevention do work. What we lack are the instruments in order to be able to implement this through health care financing.

I was going to refer to one piece of legislation, and I will end on that. One piece of legislation relates to H.R. 2543, which is a piece of legislation, a very simple piece of legislation, tc have HCFA pay for the cost of a special shoe in order to prevent patients from going on to amputations. The use of special shoes and the use of patient education programs can decrease the rate of amputation by a factor of 50 percent, a tremendous cost saving not just in terms of human well-being, human considerations, but also monetary savings as well.

Thank you, Mr. Chairman.

Senator **Durenberger**. Thank you very much.

Jim.

[Dr. Sussman's written testimony follows:]

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TESTIMONY

of

Karl Sussman, M.D.

President, American Diabetes Association

Before

The Senate Finance Committee

Mr. Chairman,

My name is Karl Sussman. I am currently President of the American Diabetes Association which has 58 affiliated associations and 200,000 lay and professional members. I am also a physician involved in clinical care and research within the Veteran's Administration health care system. I am also Acting Associate Chief of Staff for Research and Development at the VA Medical Center, and Professor of Medicine at the University of Colorado School of Medicine in Denver.

The American Diabetes Association is pleased to be able to participate in this hearing and we appreciate this opportunity to testify before this distinguished committee about preventive care, health promotion and their impact on the quality of patient life and costs to Medicare and other payment sources. We have a major investment in health promotion and preventive care in our public awareness programs, our professional education programs and our journals for both consumers and professionals. In 1984, we jointly sponsored a major conference on financing improved care particularly emphasizing preventive techniques. Also sponsoring this program were the Department of HHS, Centers for Disease Control, and the National Diabetes Advisory Board. We also conducted a major clinical education program for primary care physicians which reached 30,000 physicians and brought to them the newest of techniques in managing Type II diabetes. We published a physician's guide to Type II diabetes as part of this program. I will discuss many of these new methods of care in my testimony. Mr. Chairman, we in the private sector are doing our part also to improve care,keep costs and improve the quality of life for patients.

Background Information on Diabetes and Preventive Care

There are approximately 5.5 million Americans who have been diagnosed as diabetic and about 2.1 million are age 65 and over. Each year approximately 500,000 new cases of diabetes are diagnosed. Diabetes and the complications that accompany it present an enormous economic burden to our health care system generally and to the Medicare Program. Yet if diabetes and its accompanying complications are properly controlled, a great number of hospitalizations and the related costs can be prevented.

Uncontrolled diabetes results in several complications. In fact, it is the complications caused by the disease rather than the disease itself that are the most damaging both in terms of human lives and cost to our health care system. People with diabetes face a shortened life span and are subject to a variety of long term complications including kidney failure, blindness, amputations of the lower limbs, heart attacks, strokes, and neurological disorders. Uncontrolled diabetes can also result in the acute complication known as diabetic ketoacidosis, a condition that can lead to coma and to death. Diabetes also represents a significant risk to pregnant women and their babies. Diabetic women have a signicantly higher risk of miscarriage and other obstetrical complications as well as a high incidence of birth defects, early infant mortality and illness requiring intensive medical care in the early days of life. While obviously, the complications of pregnancies are not matters with which Medicare is particularly concerned, though disabled women can be of child bearing age and on Medicare, they do affect Medicaid, and result in high costs to the health care system generally. Generally, Medicare coverage decisions have significant affects on Medicaid and private insurance and, therefore, it is important to assure reasonable coverage in Medicare even if there may be few individuals affected.

It is estimated that the total direct cost born by the health care system in treating diabetes and its complications is approximately $7.4 billion. Since about 40% of diabetics are 65 and over, we estimate that approximately $3 billion of the $7.4 billion is born by the Medicare system. Diabetes DRG 294 is the 9th most costly DRG according to 1982 HCFA Medicare data and the 21st most prevalent Medicare admission according to the most recent data. There are other DRGs which are diabetes admissions as well including DRG 285 for lower limb amputations.

There are many things that can be done to reduce these costs and to improve the quality of life for diabetics at the same time. First I will discuss some of the risk factors associated with diabetes generally and steps that can be taken in reducing or preventing them and, thereby, preventing the onset of the disease. This is primary prevention. I will then discuss the five major complications associated with diabetes and specific measures that can be taken to reduce their occurence. This is a matter of secondary prevention.

Obesity, hypertension, and poor metabolic control are the most important risk factors in diabetes. They also exacerbate the condition and increase the risk of complications if one becomes diabetic. The chances of someone who is obese becoming diabetic is more than twice that of the non-obese person. It is also estimated that about 85% of diabetics are overweight. Obesity plays a prominent role in Type II diabetes which is generally defined as adult onset, non-insulin dependent and is by far the most prevalent form of diabetes. For these individuals, a proper diet and exercise program is extremely important. Even a modest reduction in body weight can usually result in improved insulin sensitivity and even improved insulin secretion.

Diabetes is also most prevalent in those with diabetes in the family. A primary preventive technique is, therefore, to identify the high risk patients and obtain control of their weight. Related to the obesity problem is high blood pressure or hypertension. This condition affects a large proportion of diabetics.

Reducing high blood pressure (hypertension) can also help prevent many of the complications of diabetes. Reducing smoking also assists greatly in preventing complications. Poor control of blood glucose or poor metabolic control is another serious problem which can contribute to the development of many complications associated with diabetes. Proper patient education and the use of new and existing technology can aid remarkably in the reduction of these risk factors related to complications.

Prevention Techniques

By far the most important technique in preventing the complications of diabetes is patient education in self-care. This is something that we know works based on data from several projects carried out throughout the country, many supported by the Centers for Disease Control, Diabetes Control Program. A project at Grady Memorial Hospital in Atlanta, Georgia which provided patient education and diet therapy to 10,500 cases over a 10 year period, estimated that the program prevented almost 1,500 cases of diabetic ketoacidosis between 1975 and 1980. Further, it estimated that the number of lower extremity amputations prevented was 555. Preventable hospitalizations were estimated to have decreased from 670 per thousand in 1968 before the project was started to 130 per thousand in 1972. A project in the state of Maine, the Maine Ambulatory Diabetic Education and Follow-up Program which provided out-patient education, documented a 39.8% reduction in the number of diabetics hospitalized for all conditions, a reduction of 32.2% in the number of hospital days and a savings of approximately $360,000 in hospitalization costs. A similar project in Michigan which included home visits to recently hospitalized diabetics to help them with the management of their disease showed a 43% reduction in the total number of hospital admissions and as well as a reduction in the average length of stay for those who did have readmissions. Outpatient education classes conducted in a Rhode Island project demonstrated a 58% reduction in hospital admisssions for preventable complications of diabetes. The total persons requiring hospitalizations decreased by 48%. These are only a few of the efforts throughout the country to improve patient education for diabetics. However, outpatient education is not generally reimburseable under federal and private health insurance programs. As I will discuss further on, this is an area that Congress needs to address within the Medicare system.

Recent advances in technology greatly improve metabolic control of diabetes and thereby lessen the likelihood of complications such as blindness, amputations and kidney disease. Recently, research at the National Eye Institute produced a laser therapy treatment for individuals with diabetic retinopathy. Another new technology is the external insulin pump. It has been demonstrated that the use of the insulin infusion pump can result in better diabetes control for certain well-defined groups including pregnant women and adolescents. It is an important new technology whose benefits we are still learning about. Another technology which aids in metabolic control of diabetes is the home glucose monitor. This is a device that can be used at home for monitoring the level of blood glucose. This device can help both insulin dependent and non-insulin dependent patients have better control over their diabetes. The insulin pump is not covered under Medicare and the home glucose monitoring device is only covered under certain limited conditions. A third and very important preventive measure for the foot disease and amputations associated with diabetes is the use of specially fitted and molded therapeutic shoes. Medicare does not currently cover therapeutic shoes, though H.R. 2543, a bill recently introduced in the House which would provide this coverage. The cost of the shoes is a significant barrier to their acquisition. Increased availability could do much to prevent diabetic foot disease and ultimately amputations. As technology develops, patient education in its use becomes extremely important. The new technology in diabetes such as pumps and home glucose monitors are methods of self-care and patients need to be prepared to use them effectively.

Specific Complications and Methods to Prevent Them

1. Diabetic Retinopathy and Visual Impairment

Diabetes is the major cause of blindness in the country with 5,000 new cases reported annually. Diabetes causes retinopathy which results in visual impairment. 50% of all people with diabetes have retinopathy 10 years after the diagnosis of diabetes. Between 500,000 and one million aged indivuals have diabetic retinopathy since there are 2.1 million diabetics over 65 and many of them have been diagnosed for 10 years.

Preventive care for some cases of diabetic retinopathy are well developed and being utilized. Research continues to expand the preventive techniques. Photocoagulation by means of laser therapy will reduce the risk of visual loss by 60%. This method works for patients with proliferative or advanced retinopathy. A major National Eye Institute (NEI) trial is exploring the use of laser therapy in the early stages of retinopathy. The NEI has data showing that this laser therapy procedure now saves SSI and Medicaid $25 million annually in reduced disability payments and reduced use of health care services. These savings would be multiplied a number of times if Medicare and SSDI data were available, but it is not at present. The diagnosis and treatment of hypertension appears associated with an increased incidence of diabetic retinopathy. It is also believed that the use of new technology to more strictly control blood sugar levels will reduce the incidence of diabetic retinopathy.

2. Foot Complications

Diabetics are particularly prone to foot disease. Many suffer from peripheral neuropathy or loss of feeling or sensation in the extremities. This can lead to repeated injury or trauma resulting in ulceration and infections. Diabetics also suffer from peripheral vascular disease which causes the blood supply to the lower extremities to be severely diminished. This prevents the healing of ulcers and infections. Ultimately, this can lead to gangrene and amputations.

It is estimated that at least 40,000 diabetics are required to have a lower extremity amputation each year. Between 17,500 and 25,000 of these are believed to occur in individuals 65 and over.

The rate of amputations could be substantially diminished if proper foot care were available. This involves patient education about proper foot care and where appropriate, the use of special shoes. The Veterans Administration presently offers such a specialized program and generally estimates substantial savings from reduced rates of hospitalization and amputations. If proper foot care were available, it is estimated that the rate of amputations could be reduced by 40% according to research from England and this country. If we assume that 17,500 of the 40,000 amputations per year occur among Medicare beneficiaries, and 40% or 7,000, were prevented the net savings to Medicare if foot care including shoes were available would be about $86 million. This represents the cost of providing shoes to diabetics with severe diabetic foot disease (estimated to be about 60,000 individuals) subtracted from the cost of amputations expected to be prevented.

Existing programs show that this is an effective prevention technique. The Grady Memorial Hospital Diabetes Program was able to reduce amputations by approximately 40% where individuals were provided with proper foot care including shoes where indicated and affordable. At another study at Kings College in London, amputations were reduced almost 50% where individuals were involved in a foot care program which included special shoes. That same study found that the recurrence of diabetic foot ulcers for individuals furnished with therapeutic shoes was only 19% compared to a 91% rate of recurrence fcr individuals who wore regular shoes. However, even though we know that many of these amputations could be prevented through proper foot care and the availability of shoes, there are very few programs in place to accomplish this. This is partly due to lack of reimbursement for outpatient education and for therapeutic shoes under Medicare, private insurance and Medicaid.

3. Diabetic Ketoacidosis and Coma

A third complication associated with diabetes is diabetic ketoacidosis or diabetic coma. This is a severe complication caused by an insufficient level of circulating insulin. If it is left untreated or not treated properly, it can result in death. Further, it invariably accelerates other health problems later in life. This complication can be almost totally prevented if the patient receives optimal medical care and adheres to a prescribed treatment regimen. Self-blood glucose monitoring through home kits can play an important role in preventing diabetic ketoacidosis as can close metabolic control by use of insulin infusion pumps. Patient education in the use of this technology is important to its effective use. This complication can also be prevented by making health care practitioners aware of symptoms of this condition and how best to treat it. The Grady Memorial Hospital study referred to above reduced the number of hospitalizations for diabetic ketoacidosis by approximately 1,462 between 1975 and 1980.

4. Kidney Disease

Another complication is kidney disease or nephropathy and is potentially the most costly. About 4,000 cases of end stage renal disease occur annually among diabetic people. Patients diagnosed as having diabetes before age 20 have a 50% chance of developing renal disease. About 25% of all cases of end state renal failure are attributable to diabetes. The annual cost for diabetic patients under the Medicare funded end stage renal disease program is currently about 200 million per year and growing rapidly. Kidney damage also leads to the elevation of blood pressure which in turn may further aggravate renal damage as well as the other complications of diabetes.

It is reasonably well established that the best way to prevent kidney complications is to prevent the pre-disposing factors including hypertension and urinary tract infections. While the course of diabetic nephropathy is not completely understood, it is believed that the prevention of these risk factors associated with it are the best way to prevent kidney disease itself. Patient education plays an important role in this preventive care as well as monitoring of a diabetic patient's renal function. Avoiding episodes of ketoacidosis is also important in preventing or postponing renal disease. Once structural damage to the kidneys is advanced, the disease progresses rapidly and the only treatments are dialysis and kidney transplantation.

Evidence has been accumulating that the use of the insulin infusion pump will reduce risk factors associated with kidney disease and will result in better management of diabetic kidney disease. Proteinuria is usually the first indication of renal disease and close control of blood sugar may well reduce proteinuria substantially.

5. Diabetic Pregnancy

Diabetes is a major risk factor in complications associated with pregnancy. In addition to the approximately 14,000 babies born each year to diabetic women, 90,000 babies are born to women who develop gestational diabetes during pregnancy. The mortality rate for infants of diabetic mothers is extremely high, with approximately 4,500 deaths occuring on or about the date of birth each year. These infants also experience high rates of congenital malformations and anomalies, respiratory distress, prematurity and other serious medical problems.

Patients suffering from diabetes during pregnancy are generally classified on the basis of the time of onset, the severity of the diabetic condition and the presence of complications. Most of the morbidity for infants of diabetic mothers occurs in women who are insulin-dependent prior to pregnancy, and the risk of death, severe birth defects, and other serious complications increases for mothers who have been insulin-dependent for ten years or more. Studies have shown that between 6 and 12% of diabetic pregnant women will give birth to infants with major congenital malformations. This means about 6,000 to 12,000 disabled infants are born of diabetic mothers.

Hormonal and metabolic changes of pregnancy result in the diagnosis of gestational diabetes for 20-30,000 pregnant women each year. This prevalence of diabetic reactions among women who become pregnant necessitates testing of all pregnant women between the 24th and 28th week of gestation in order to identify glucose intolerance. A diagnosis of gestational diabetes requires the immediate implementation of strict dietary controls and/or insulin therapy to prevent maternal weight loss and fluctuating blood glucose levels, both of which can pose a serious threat to embryonic development.

During the 1970s, medical research demonstrated that diabetes control had helped to decrease fetal and new born death rates, but that the incidence of birth defects remained three to six times higher than usual. Further research has pointed up the importance of maintaining proper control of glucose levels during the early stages of pregnancy, when organs most frequently affected by congenital malformations -- including the heart, brain, and spinal cord -- are just beginning to develop. These conclusions demonstrate the need to ensure excellent control over blood sugar levels immediately from the time of conception, rather than simply at the time when women discover that they are pregnant some six to eight weeks later.

A number of preventative measures, both educational and technological, are available to assist in the maintenance of excellent diabetes control throughout the gestational period. Patient education and management programs, initiated prior to the time when the diabetic woman may become pregnant, are essential to maintenance of tight control. Instruction regarding nutrition, exercise, insulin therapy, glucose assessment and pregnancy planning schould be provided through the combined efforts of diabetes educators, prenatal nurses, nutritionists, social workers and physicians. Early active patient, spouse and family participation in educational programs is essential for success of a pregnancy complicated by diabetes.

The use of self-blood glucose monitors is an important mechanism for obtaining accurate blood sugar analysis because uring testing is not a senstive enough indicator of satisfactory blood glucose levels. Blood glucose testing is needed throughout pregnancy to minimize the possibility to hyperglycemia.

The subcutaneous insulin pump is achieving increasing medical accpetance in the treatment of diabetic women who are pregnant. The pump, which is portable and externally worn, provides continuous infusions of insulin in carefully measured dosages. Pump use has been shown to decrease the incidence of abnormally large babies born to women affected by gestational diabetes. Given propr understanding by the patient, the pump can be used in conjunction with self-blood glucose monitoring equipment to achieve more consistent and successful control over blood sugar levels.

Recommendations Regarding Medicare Reimbursement and Preventive Care

1. The lack of reimbursement for many prevention techniques is a significant obstacle to effective prevention and control of diabetes. While third party payors may recognize the role of patient education in reducing diabetes morbidity and mortality, they routinely reimburse only where education is provided during a hospital stay. While Medicare does not specifically mention patient education as a covered item, it can be covered under the more general provisions. Medicare has determined that "resonable and necessary" patient education programs may be covered as a physician service or as a paramedical service "incident to" a physician service. However, this makes reimbursement for outpatient education programs problematic unless they conform to

the strict requirements of "incident to" physician services including strict physician supervision. Much patient education can be done by nurse practitioners and registered dietitians and it can be done in group sessions. We believe it would be important for Medicare to permit reimbursement for patient education on an outpatient basis and in groups by allied health professionals even if not strictly incident to physician services, where provided in organized settings which meet appropriate criteria of quality. The National Diabetes Advisory Board has developed such criteria for patient education programs and we shall submit the criteria for the record.

2. Medicare coverage for new diabetes technologies is also becoming an issue of increasing importance. As I mentioned above, Medicare does not provide coverage for therapeutic shoes. H.R. 2543 would provide that kind of coverage. We estimate a savings of about $86 million annually if the bill were enacted. Our cost estimates and the bill are submitted for the record. This legislation would cover special therapeutic shoes for diabetics with diagnosed diabetic neuropathy and with evidence of severe foot disease including deformed and severly ulcerated feet. The shoes would be specially designed to fit and protect the diseased foot and enable the patient to walk much more easily and without exacerbating the disease. The shoe would be provided only upon the prescription of a physician, including podiatrists, who also certify tha the patient is under a plan of care by a physician for his or her diabetic condition. The physician would

have to certify as well that the patient was going to benefit from the use of the shoes in terms of improved foot condition and lessened likelihood of further complications. We also would assure quality control by having a prior authorization from a PRO or intermediary as to the appropriateness of the shoe.

Medicare does not now cover insulin pumps although it did prior to 1985. We believe insulin pumps have a demonstrated benefit for certain individuals and should be covered accordingly for those patients. We have developed a specific policy on this matter and it will be before our Board this weekend. We then intend to recommend this policy to HCFA to replace their current policy denying coverage entirely.

Another reimbursement issue is home glucose monitoring. Blood glucose monitors are meter devices which evaluate blood glucose levels on the basis of color changes produced on specially treated reagent strips in reaction to glucose concentrations in the patient's blood. The patient makes use of the device by drawing a drop of blood with a disposable sterile lancet, and placing it in the reagent strip. Thereafter, the reactive strip is placed into the monitoring device. Medicare coverage policy for this device is quite limited. In order for a patient to qualify for Medicare coverage of a home glucose monitor, the patient must be insulin-dependent. In addition, the patient's physician must document that the individual's condition is characterized by poor diabetic control consisting of:

a) widely fluctuating blood sugars,

b) frequent episodes of insulin reactions, or

c) evidence of frequent significant insulin reactions.

The physician must state that the patient is capable of being trained to use the particular device for which coverage is sought. Finally, the device must be designed for home rather than clinical use. Home glucose monitoring systems are a highly effective means of assisting many diabetics in monitoring excellent control over blood sugar levels. For example, as discussed above, pregnant women with diabetes are prone to fluctuations, and the home monitors are achieving rapid acceptance as a means for combatting this problem. We believe the medical reimbursement policy for this device is restrictive. In effect, the conditions requires that an individual patient actually be the victim of uncontrolled blood sugars and/or insulin reactions before the system will be covered. This policy is inconsistent with the key objective of home glucose monitoring which is to prevent fluctuating blood sugars and insulin reactions from ever occuring.

We thank you for this opportunity to testify and are available to answer questions.

STATEMENT BY JAMES L. REINERTSEN, M.D., PRESIDENT, PARK NICOLLET MEDICAL FOUNDATION, MINNEAPOLIS, MN

Dr. REINERTSEN. Senator, I find myself in the position of seconding the motions of the previous two speakers.

I am a rheumatologist, an internist specializing in arthritis and rheumatic diseases. I practice at the smoke-free Park Nicollet Medical Center, a 275-physician group practice in Minneapolis, which includes among its activities a 200,000-member HMO and a Medicare demonstration HMO component.

In addition to my clinical practice, I am president of the Park Nicollet Medical Foundation, the primary mission of which is to promote research and education in self-care, disease prevention, and related health services.

I wish to speak in support of the extension of Medicare benefits for preventive and health-promoting services, particularly for those services which enable the elderly to cope and live well with chronic disease.

The Medicare population, because of its age distribution, contains a high proportion of persons with some chronic illness or disability. Forty-four percent of those over age 65 have some disability that limits full function; in 23 percent this is moderate or severe. I see little reason to believe that this proportion will decrease dramatically, at least in the near future, unless some of the preventive activities you have been talking about earlier in the hearing are applied very effectively over the entire age spectrum. It may even increase as longevity continues to rise.

I therefore believe that the Medicare system's major challenge and opportunity is not so much to prevent these conditions outright, but to help its beneficiaries live well with them. Failure to do so will mean that we will continue to pay for the complications of those chronic conditions, a policy far more expensive than paying to develop the knowledge and skills among the Medicare population to prevent them.

I would like to cite two example programs, one in fitness and one in diabetes education, to support this view. That is why I said I find myself seconding the motions of the previous speakers.

First, in fitness. Considerable evidence exists to support the view that old people don't wear out as they age, they rust out.

Senator DURENBERGER. They what?

Dr. REINERTSEN. They "rust out." [Laughter.]

Using the bones, muscles, and joints, along with the cardiovascular and neurologic systems in a well-designed fitness program may be one of the best means of preserving the ability to walk and therefore to remain independent. The additional benefits of fitness—increased mental alertness and vigor, better pain control, fewer falls because of better coordination, better stamina, and so forth—all combine to make fitness one of the most immediately appealing means of enhancing the functional capabilities of seniors with arthritis, emphysema, heart disease, and a host of chronic ailments.

We now know how to present fitness to the elderly. The National Council for Fitness and Aging has developed guidelines for senior exercise programs. An example of such a program is Over Fifty and Fit, which we developed at Park Nicollet with help from the Metronic Foundation. Listen to these reactions of participants in this low-cost program, which is led, by the way, by senior volunteers in high rises and other centers:

> Since my retirement, arthritis has kept me from getting much exercise. I was really worried; I couldn't do any of the workout exercises, and believe me, I started very slowly. Now I can keep going for much longer in class, and the walk to the mailbox is a piece of cake.

Another one:

> I feel very good about this program. Even with my artificial knees I can do most exercises and have noted real progress as I continue the program.

The processes of aging, then, and deconditioning resemble each other so closely that some researchers estimate that 20 percent of hospitalizations for the elderly would be eliminated by widespread participation in safe, medically designed programs such as Over Fifty and Fit.

I believe they are right, and that demonstration projects under S. 359 would show this.

On the side of diabetes, which provides by the way a more focused example of an opportunity to spend dollars well, current Medicare policy pays for diabetes-related renal dialysis, amputations, blindness care and so forth, but it does not pay for outpatient education programs to prevent these costly problems. Exceptions to the policy exist in Maine and Michigan where studies, interestingly enough, have shown the education programs to reduce hospitalizations by 43 percent, saving $300 per year per diabetic. When one considers that 1 in 20 Americans has diabetes and that this proportion is higher in seniors, one realizes the magnitude of the savings potential.

The data are in, then, demonstrating cost effectiveness of diabetes education. Furthermore, the National Diabetes Advisory Board has now published standards for outpatient diabetes education, which mirror closely, I am proud to say, the programs of the International Diabetes Center, one of our divisions in the foundation.

It is time to take the data and the standards and formulate a national policy under which Medicare would pay for this preventive process.

You know better than I how ill-equipped the Nation is to continue to pay surgeons to amputate gangrenous diabetic feet, and nephrologists to attach dialysis machines to people with failing kidneys, when we could pay educators to teach patients to care for themselves so as to avoid these tragedies.

Let me close by citing a 16th-century description of aging and activity given by a Spanish physician:

> The fifth age is old age, which is past 40 or more years, and in this age the proper exercise is to ride a mule or to walk for a while on foot. The sixth age, which is decrepitude, from 70 years on, requires gentle movement and the use of temperance.

I would like to suggest we have come a long way in this Nation since the 16th century. As a nation, we do not want and we cannot afford decrepitude from 70 years on.

Thank you.

Senator **Durenberger**. Thank you very much.

[Dr. Reinsertsen's written testimony follows:]

Statement of

James L. Reinertsen, M.D., President

Park Nicollet Medical Foundation

Minneapolis, Minnesota

to the

UNITED STATES SENATE FINANCE COMMITTEE

SUBCOMMITTEE ON HEALTH

HEARING ON

HEALTH PROMOTION AND DISEASE PREVENTION

June 14, 1985

PRECIS

General principles of health promotion are applicable to older Americans, but the high prevalence of chronic diseases among the elderly requires that special emphasis be placed on helping them live well with chronic disease, rather than purely preventive approaches.

This paper describes two examples of programs which could limit disability and medical costs for older Americans who have chronic conditions of aging.

1. Fitness. Aging and deconditioning bear a remarkable resemblance. Many major causes of disability, hospitalization, and nursing home admission could be reduced by widespread access to fitness activities for the elderly. The "Over 50 and Fit" program is an example of a program specifically designed to meet the special needs of older people.

2. Diabetes education. Many of the complications of diabetes are preventable through education as exemplified by the programs of the International Diabetes Center. Such programs could prevent the disability and cost of up to 20 percent of diabetes-related blindness, renal disease, and amputations. Other chronic disease self care education programs could be based on this model.

I recommend that the Committee

1. Create financial incentives to encourage older Americans to participate in fitness programs designed to meet their needs.

2. Support chronic disease self care education programs within the Medicare benefits structure by reimbursement for tuition and class fees.

STATEMENT

Within the next 15 years, the proportion of the Federal budget devoted to persons over 65 will increase to 32 percent.[1] These dollars will be spent in a number of ways, but a large proportion will go to the institutions and professionals who care for the mentally and physically disabled. At present, 44.3 percent of those over 65 have some disability that limits full function, and 21 percent of those over 85 are in nursing homes or other long term care facilities.[2,3] If we are to limit the impact of their disability and illness on their lives, and correspondingly to limit the impact on the Federal budget, the principles of health promotion will need to be applied to the elderly in a carefully crafted national program.

Although all facets of health promotion (safety and accident prevention, chemical and tobacco use, mental well-being, fitness, and nutrition) apply to the elderly, the high prevalence in this population of chronic illnesses such as arthritis, cardiovascular disease, and diabetes requires that health promotion programs for the Medicare-eligible place special emphasis on helping them to live well with chronic diseases. My testimony will focus on two examples of programs in fitness and diabetes which can meet this challenge--helping the elderly to cope well with chronic disease--rather than on purely preventive aspects of health promotion which are more effectively applied to our youngest citizens. It is my thesis that widespread availability of such programs to Medicare beneficiaries would be an extraordinarily powerful way to limit unnecessary disability and cost.

Fitness

The processes of aging and physical deconditioning are remarkably similar physiologically.[4] Only 30 percent of those over age 65 exercise regularly, and this lack of activity may accelerate some of the most debilitating changes associated with aging. For example, hip fractures from falls are more likely in those elderly patients who are obese, weak, osteoporotic, and lacking in coordination--all factors associated with sedentary lifestyles. Even mental acuity declines more in sedentary than in active elderly persons.[5] When the cardiovascular risks of deconditioning are added, it is therefore not surprising that admissions to institutionalized care for the elderly might be reduced as much as 20 percent by widespread participation in fitness programs.[6]

In 1981, the Park Nicollet Medical Foundation, with major funding from the Medtronic Foundation, developed a fitness program specifically designed for the senior population. This program, "Over 50 and Fit," is based on sound principles of safe exercise and is accessible to all but the most severely handicapped elderly. It is entirely led by volunteers from among the ranks of the elderly and is successfully operating in senior citizen centers and high rises around the Twin Cities.

While data have not accumulated yet to show that "Over 50 and Fit" reduces medical costs, it is clear from participants' reactions that their ability to cope with minor and moderate degrees of functional impairment (e.g., from arthritis, the most common cause of disability among the elderly) is significantly improved. I believe that "Over 50 and Fit," and similar programs, if they were easily accessible and widely available around the country, could help our burgeoning Medicare-eligible population live well with their various age-related ailments.

I strongly urge the Finance Committee to consider ways by which Medicare beneficiaries could be financially supported when they participate in fitness programs such as "Over 50 and Fit." I believe that the cost of such incentives would be more than justified by reduction in other costs--particularly in medical costs related to cardiovascular and rheumatic diseases and in psychiatric care. We have come a long ways from Dr. Mendez' 1553 description of aging and exercise: "The fifth age is old age, which is past 40 or more years, and in this one the proper exercise is to ride a mule or to walk for a while on foot . . .. The proper exercise for this and the sixth age, which is decrepitude from 70 years on, is gentle movement and use of temperance in everything he has been used to."[7] As a nation, we do not want and cannot afford "decrepitude from 70 years on."

Diabetes

Diabetes is a major and costly chronic disease affecting older Americans. It affects 1 in 20 Americans and is responsible for a large number of costly complications among the elderly, including nerve damage, blindness, heart attacks and strokes, kidney failure, and amputations. For example, 40 percent of amputations after age 45 are due to diabetes.[8] As the proportion of seniors who are obese grows, the likelihood of higher diabetes-related costs increases.

Much can be done to curb these costs and to limit the disease and its complications. Most important would be a nationwide effort to increase physical activity, which would in turn reduce obesity, the chief non-genetic risk factor for diabetes. Despite such programs, however, many Americans will develop diabetes, and it is by helping them, their families, and their health professionals to optimally manage their diabetes that complications like amputations and blindness could be forestalled. At least 20 percent of both blindness and amputations are thought to be entirely preventable by better diabetes management. Twenty-five percent of dialysis patients in the $1.8 billion End

Stage Renal Disease Program are diabetic; many of them would not need to be there if optimal self care and diabetes management were practiced. What is needed is widespread knowledge and experience among diabetics in principles of self care and advanced diabetes management.

The International Diabetes Center (IDC) has pioneered programs which could meet this challenge in health education, self care, and professional education. This institution, which is a division of the Park Nicollet Medical Foundation and headquartered in Minneapolis, enables patients to "live well with diabetes" through in-depth, practical programs for individuals with diabetes and their families, as well as for their health professionals. The IDC's programs are generally recognized internationally as a model for teaching self care in chronic disease.

Some insurance carriers have recognized the enormous potential for programs such as the IDC's to prevent complications and lower costs and have begun to subsidize enrollees' participation. I believe it is time for the Federal government to consider spending Medicare dollars for preventive programs for older diabetics, rather than for amputations, dialysis, and impotence devices.

Furthermore, there are many other chronic illnesses, such as arthritis and chronic lung disease, among the elderly for which disease-specific education programs could make a significant impact on disability and costs. The goal would be to enable our older Americans to live well with whatever chronic conditions the aging process brings them. Failure to do so in a time of rapid expansion of the senior population will mean increasing numbers of frail elderly and staggering increases in the cost of their care.

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Senator **DURENBERGER**. We thank all of you. I indicated I am going to miss my plane unless we conclude this hearing, but let me conclude with one observation:

We may be, Dr. Jette, preaching here to the converted, but I know there is one person in this room, and probably more, who are a whale of a lot better informed as a converted person than we were 3 hours ago. This has been a most enlightening hearing, and from my standpoint particularly comprehensive. My own view of disease prevention and wellness promotion has changed a lot in the last 2½ hours, and I am grateful to all of the witnesses, and to this panel in particular.

Thank you very much. The hearing is adjourned.

[Whereupon, at 12:09 a.m., the hearing was concluded.]

[By direction of the chairman the following communications were made a part of the hearing record:]

STATEMENT OF
THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS

on

Financing Graduate Medical Education

Submitted to the
Subcommitee on Health
Committee on Finance
United States Senate

June 12, 1985

The American College of Obstetricians and Gynecologists (ACOG) is an organization of over 25,000 physicians specializing in the delivery of health care to women. On behalf of our members, we would like to share our views on the funding of graduate medical education.

There are currently 293 approved residency training programs in obstetrics and gynecology throughout the United States, training 4,704 residents. To complete training in obstetrics and gynecology, a resident must have a minimum of four years of approved clinically oriented graduate medical education of which at least three years must be entirely in the specialty of obstetrics and gynecology. Residents in obstetrics and gynecology represent approximately 6 percent of the total number of residents in graduate medical education.

The current system of financing graduate medical education relies almost exclusively upon patient care revenues generated by the hospital. As the single largest source of hospital revenue, Medicare's contribution to medical education is thus significant. In part, this strategy of financing medical education via patient care revenues is a valid recognition of the large measure of patient care provided by residents in training, particularly care provided to indigents in both public and private hospitals. However, an inequity exists when, as a society, we rely exclusively upon charges to the sick and elderly to finance training of physicians from which all of society benefits. Furthermore, in a competitive health care environment, teaching hospitals are placed at a disadvantage if they must pass on to patients the cost of training in order to maintain these programs.

The ACOG believes that ideally, research and education necessary to maintain and improve the collective capacity to provide health care -- insofar as they are a public responsibility -- should be financed to reflect that fact, rather than relying for their support on patient care dollars. However, change to implement this principle must be approached in a way that will minimize disruption of the current strengths of and support for research and education.

The Administration has put forth two proposals in its budget for fiscal year 1986 which would reduce the availability of Medicare trust funds to pay for graduate medical education. This reduction would be accomplished through a freeze on direct support to hospitals for interns' and residents' salaries and a 50 percent reduction in the adjustment for each Medicare patient treated in teaching hospitals (indirect medical education). Because these proposals would be implemented with no corresponding alternative to maintain public support for graduate medical education (and indeed, limited federal support for certain residency training programs under Title VII of the Public Health Service Act would be eliminated altogether), we cannot support them.

The Administration cites a dual rationale for its proposals with respect to the Medicare trust funds: reductions in the level of support for graduate medical education are needed in order to improve the solvency of the trust funds, and secondly, the projected number of physicians in practice or in training constitutes a surplus which warrants a reexamination and reduction in the level of federal support for medical education.

Issues of physician specialty and geographic distribution have also been raised in recent policy debates. It has been suggested that federal support should be targeted toward the primary care specialties in order to achieve a more desirable mixture of primary care providers and specialists. Some policymakers believe this goal can be achieved by a federal requirement that an arbitrary percentage of residency slots be devoted to training primary care providers if an institution is to qualify for federal support or, alternatively, that federal training funds be time limited, for example -- that only the first three years of training be supported. We believe such an unprecedented attempt to direct manpower policy through use of the Medicare trust funds warrants more extensive discussion and debate than can be achieved solely within the context of the budget process.

With respect to the emphasis on increasing the numbers of primary care providers, we would like to clarify the role of the obstetrician-gynecologist in women's health care. Obstetrician-gynecologists are specialists who provide health care for women with particular reference to the female reproductive system. In addition to applying knowledge and skills to a specific organ system, they are involved in the care of the whole patient. Obstetrician-gynecologists are the principal access and source of medical care and advice for many women throughout their adult lives and may be their only regular medical contact. Almost 80 percent of the patients seen by an obstetrician-gynecologist are on a self-referred basis; while under his or her care, 70 percent receive the majority of their patient care from the obstetrician-gynecologist.

According to the National Ambulatory Medical Care Survey conducted by the National Center for Health Statistics, obstetrics and gynecology ranked fourth among all specialties in the number of physician office visits. Of all visits to physicians' offices by women in the age group 15-44 years, 30 percent were to obstetrician-gynecologists, nearly equal to the 32 percent of such visits made to general and family practitioners. Among the major reasons for visits to obstetrician-gynecologists are routine prenatal care, gynecological examinations, and contraceptive management. Together, these account for 49 percent of ob/gyn visits. Obstetrician-gynecologists provided 76.9 percent of all prenatal care in 1981 (up from 72.1 percent in 1975), 85.1 percent of all gynecological examinations, and 75.9 percent of all contraceptive management.

We believe any attempt to target federal support to training primary care providers must include training of obstetrician-gynecologists. Furthermore, to avoid disruption of the many excellent training programs in this specialty and to maintain the quality of patient care provided, support should not be limited to three years without assurances that alternative funding sources will be available for residents to complete the fourth year of training.

The functions of a teaching hospital include patient care, education of residents, research, and often, indigent care. Interrelated in a complex way, these functions cannot withstand the proposed loss of $845 million in FY 1986 without jeopardy to the entire system. We urge the Congress not to act precipitously and without assurances that funding mechanisms will be in place to both maintain and improve the present system of graduate medical education and to continue care for indigent patients.

THE AMERICAN DIETETIC ASSOCIATION
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June 21, 1985

The Honorable Dave Durenberger, Chairman
Subcommittee on Health
Committee on Finance
219 Dirksen Senate Office Building
Washington, D.C. 20510

Dear Senator Durenberger:

The American Dietetic Association (ADA), a national organization of more than 50,000 nutrition professionals, welcomes the opportunity to share our comments and recommendations on the role of nutrition in health promotion and disease prevention. Please include this letter in the published record of your June 14 hearing on health promotion and disease prevention for Medicare beneficiaries.

During the last decade, research has increasingly identified the link between nutrition and health. An NIH which panel has suggested that as many as 34 million Americans have a level of obesity close to 20 percent or more of the recommended ideal body weight. This panel has recommended that those individuals who fall into this category be treated. Obesity has been associated with several disorders including heart disease, hypertension, hypercholesterolemia and diabetes. Treatment of obesity with nutrition intervention is more than simply preventive. Through successful weight reduction and behavior modification, individuals are less likely to return to their obese state: therefore, the obesity and its complications (e.g., diabetes) have been treated. This can significantly improve quality of life, and also result in significant savings to the health care system. For example, in a 1979 study on the use of nutrition intervention in treating diabetic patients, it was demonstrated that diet management and weight loss resulted in the reduced use of insulin and other medications. It was estimated that over an eight year period, a savings of $90,609 was realized. In addition,

$37,000 was saved by averting the need for emergency room admission and surgery cost for amputation.(1)

The NIH panel on lowering blood cholesterol to prevent heart disease recommended that those individuals with high and moderate blood cholesterol levels receive dietary treatment from a physician, dietitian or other health professionals. General guidelines were recommended for those individuals with low or normal levels as well. In general, these included adopting a diet with reduced levels of fat, and reduced calories if needed to reduce body weight. While the latter guidelines are perceived as steps to prevent high cholesterol and possibly future heart disease, nutrition intervention for those individuals with moderate to high blood cholesterol levels is necesary for the treatment and management of their disease.

Osteoporosis in this country has reached epidemic proportions. More than one million fractures in persons over the age of 45 can be attributed to this disease. Osteoporosis has been linked to insufficient intake of calcium in the diet and must be prevented and treated by dietary intervention, primarily in the form of education and increased consumption of calcium.

The ADA recognizes the important role of nutrition in producing a positive outcome for different disease states and in prevention care as well. Of equal importance, is the problem of access to care, particularly in the Medicare population. Without the necessary reimbursement for nutrition services, many individuals must go without such health care. We strongly urge that nutrition services be received as a bonafide reimbursement service to enable access to such health care. For example, diabetes outpatient education programs are not routinely reimbursed at this time. We recommend that these programs and other disease management efforts be covered by Medicare and other health insurance programs. The benefits of nutrition services are numerous. Studies have shown that nutrition intervention can lead to reduced length of stay in hospitals, reduced hospital use, reduced complication rates, lower overall medical costs and increased quality of life (2,3,4).

Finally, we applaud this panel's effort in the area of health promotion and disease prevention and support the chairman's bill, S.359, to provide for medical demonstrations in health promotion and disease prevention. We view this approach as a responsible process for determining the efficacy of covering preventive health services for the Medicare population.

If The Association can be of any assistance to you, please do not hesitate to call either our Washington counsel, Carla A. Hills, (202) 828-4400, or Catherine V. Babington, Assistant Executive Director, Office of Government Affairs, (312) 280-5091.

Sincerely,

Julian F. Haynes

Julian F. Haynes, Ph.D.
Executive Director

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TESTIMONY OF THE
AMERICAN LICENSED PRACTICAL NURSES ASSOCIATION INC.

HEALTH PROMOTION AND
DISEASE PREVENTION
FOR MEDICARE BENEFICIARIES

BEFORE THE

SENATE COMMITTEE ON FINANCE

HEALTH SUBCOMMITTEE

JUNE 14, 1985

Mr. Chairman, members of the Subcommittee, the American Licensed Practical Nurses Association Inc. strongly supports the goals stated in S.359 which seeks to provided health promotion and disease prevention strategies for Medicare beneficiaries.

Presently there are approximately 75,000 licensed practical /vocational nurses throughout the country who are an integral part of the health care team. As the nations's second largest group of health providers, LP/VN's play a vital role in the delivery of health care services. Working in a variety of medical and health settings, LP/VN's are keenly aware of our nation's health needs. LP/VN's can be found in areas such as hospitals and nursing homes and because of this experience, they are especially qualified to deal with elderly patients. Known as the "beside nurse", the role of LP/VN's is that of direct patient care. It can include rehabilitation, helping the patient with daily living, feeding, ambulatory care, and limited primary care. Through their educational background and experience, LP/VN's have had preparation in a very broad field of health care delivery and have had specific education in anatomy, physiology and the administration of medicine.

As the bedside nurse, LP/VN's the needless suffering and loss of dignity many patients suffer because there is under-utilization of health care providers and , more importantly , an outdated philosophy that medical care is synonomous with health care. The American Licensed Practical Nurses Association Inc. believes that "health care" should encompass a broad range of services designed to maintain the physical, mental, and social well-being of people. A truly comprehensive program of health care would include preventive, diagnostic, thearapeutic, and restorative care.

As the nation's second largest group of health care providers, Licensed Practical / Vocational Nurses should play a major role in the development and implementaion of this program. Participating in programs in areas such as nutrition, diet control and modification, and exercise are just a few examples where LP/VN's can play an important role in preventive health care. We are asking that members of this subcommittee keep in mind the importance of and the contribution LP/VN's can make when considering this important bill on health promotion and disease prevention.

Preventive care is sometimes thought to be "wasted" on the elderly. In America we hold the image of the elderly as weak and sickly. But this image does not serve us well. By accepting this, we accept the myth that these effects are an inevitable part of aging. The reality is that these effects are due in part to three real processes: disuse disease, chronic disease, and cellular aging. Disuse disease indicates loss of functions resulting from failure to use the physical and mental faculties. Chronic disease includes arthritis, diabetes and cardiovascular problems. This type of disease can be directly related to risk factors which are influenced heavily by lifestyle. Cellular aging occurs when changes in cellular functions came about which are an inevitable part of the aging process. In reviewing these processes, we see that the promise of good health for those over 65 is strong. By modifying the lifestyle of older Americans, we can greatly decrease the episodes of disuse and chronic disease.

In part this promise is becoming evident in the fact that America's health has improved substantially since 1965. This is patricularly true among persons over 65 years of age. In the second half of this century, the life expectancy for persons age 65 rose from 0.4 years per decade to one full year per decade. In round figures this means that the elderly in America will number between 15 and 20 million by the year 2050 as compared to between 3 and 5 million in 1985. This noticable improvement in health care can be contributed largely to preventive actions rather than to technological improvements in diagnosis and treatment. An example of this is a recently completed landmark study involving Dupont employees and coronary heart disease. This study concludes that the major reason for the striking decline of that disease was that fewer cases had been occuring rather than that people with the disease are being treated more effectively.

Medical cost have been steadily increasing. In these modern times, a three day stay in the hospital can cost as much as Three Thousand Six Hundred Dollars. Spending time in the Intensive Care Unit or the Coronary Care Unit increases that cost to One Thousand Five Hundred Dollars per day, not including medications and doctors' fees. This means an increase of Nine Hundered Dollars for the same three day stay. The American Licensed Practical Nurses Association firmly believes that preventive measures will help to reduce these rising medical costs and will improve the health of America's population. A heightened awareness of proper diet, nutrition and exercise will not only help those who are age 65 or older today, but will also set the stage for future "elderly" Americans. It is never too late to educate people to change their lifestyle for the better. Also, we should know that early indications of these problems can help prevent diseases.

As part of a profession which is dedicated to serving those in need, LP/VN's realize that to best serve our public we must do our best to prevent that need from arising. Increasing America's knowledge of preventive measures is a major step towards that goal. For this reason, the American Licensed Practical Nurses Association spports S.359 in its efforts to establish Medicare demonstration programs in health promotion and disease prevention.

As experienced health providers, LP/VN's would contribute substantially to health promotion and disease prevention. These health care providers could conduct programs in nutrition and diet. They also possess the necessary background needed to teach disease prevention and diabetes control.

This would include informing the public about the causes of diabetes such as obesity and hypertension and also educating those who have diabetes in self care. Supervision of exercise programs is another vital function which LP/VN's can provide. Through proper exercise, the causes and symptoms of problems such as heart disease and arthritis can be greatly reduced. The combination of experienced LP/VN's and programs such as health screening, risk appraisals, dietary consultations, stress reduction, exercise counseling and programs, smoking cessation and the prevention of prescription drug misuse would greatly contribute to a reduction of the needless suffering of our elderly and our population as a whole. Through a comprehensive health care program, of which prevention is a major aspect, those in the health profession can increase the publics' knowledge of proper health care, and a knowledgable public will be a healthier public.

We want to thank this Subcommittee for allowing our association the opportunity to express our support for S. 359 and we hope that prevention will become a major focal point for the health profession in years to come.

Ed - For the Record -
Health Promo Hearing -
6-14-85

AMERICAN HOLISTIC MEDICAL ASSOCIATION
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AHMA STATEMENT
SENATE FINANCE COMMITTEE HEARING
HEALTH PROMOTION, DISEASE PREVENTION
June 14, 1985

The eradication of the great epidemics -- smallpox, diphtheria, whooping cough, tetanus, polio, measles, etc. -- and the discovery of the sulpha drugs, penicillin, and the antibiotics which eliminated the menace of many infectious diseases, it was erroneously assumed that America was bound to become a nation of healthy people. Despite advancements madein diagnostic techniques, surgery, and medical practice in general, Americans have not become healthier. According to Brian Inglis and Ruth West, in the Alternative Health Guide, "In many respects, they (Americans) were not healthier than their fathers and mothers had been. At the very time the wonder drugs had been praised as life-savers for millions, Americans were not actually living longer, on balance, then they had been ten years before."

The health of Americans have continued to deteriorate: 30 million suffer with arthritis; 10 million are having treatment for mental illness; one million die annually from heart disease; and one thousand die every day from cancer.

If so many improvements and advancements have been made in science and medicine, why are so many Americans still unhealthy? Answer: The American public's destructive life style -- high fat, high cholesterol diets and sedentary living -- and the medical community's neglect of the importance of prevention in medicine.

Less than two percent of the health care budget goes toward preventive medicine. According to Dorothy Waddell, M.D., Coordinator of the Alternative Therapies Unit at San Francisco General Hospital, in an article in Healthline, March 1984, "...mainstream medicine also admits to the importance of prevention and education, but the power of the diagnostic and therapeutic tools it wields is so great that those issues tend to be pushed into the background.

WHY PREVENTIVE MEDICINE IS NEEDED

Educating patients and health professionals in preventive medicine is necessary to help reduce high health care costs. If the American public can be taught how to prevent diseases or accidents from happening, many costly operations, hospital stays, and X-rays and other diagnostic procedures, would be unnecessary. Prevention of disease should be the primary focus of medicine.

SOME PREVENTIVE THERAPIES

Biofeedback

Can be used to lower blood pressure or to reduce stress.

Nutritional Counseling

Researchers in the fields of diet and cancer say that a major fraction of cancer deaths i, this country can be avoided with proper changes in the average American diet. According to the panel on Diet, Nutrition and Cancer convened by the National Academy of Sciences, "Preliminary evidence is sufficiently persuasive to lead the panel to recommend interim dietary quidelines, that if followed may reduce the risk of cancer." They are: 1) Reduce the intake of dietary fat; 2) Increase the consumption of fruits, vegetables and whole grain cereals; 3) Consume salt-cured, smoke and charcoal-broiled foods only in moderation; and 4) Drink alcoholic beverages in moderation.

Exercise

Regular exercise promotes proper blood circulation -- particularly important to elderly Americans.

The American Holistic Medical Associaton was founded in 1978 to unite fully-licensed physicians who also practice holistic medicine. AHMA has eight goals, which include educating professionals and the public, advocating insurance coverage of holistic methods, conducting research, and trying to broaden public health policies to incorporate preventive and holistic health principles. Illness prevention is central to holistic medicine.

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[illegible]

[illegible] 1985 concerning Health Promotion [illegible] for Medicare Beneficiaries

The need to provide diabetes outpatient education for Medicare [illegible] of educational programs are [illegible] savings through decreased [illegible] reported to Congress [illegible] people have the disease [illegible] per year. This means that the number of people [illegible] cost for the disease is estimated at over [illegible] and [illegible] due to [illegible] and premature deaths. [illegible] times more frequently than non-diabetics.

Diabetes Mellitus is a deficiency or ineffective use of insulin [illegible] to effectively transport glucose into the cells to be used for energy [illegible] which the [illegible] glucose will be formed metabolically by the liver [illegible] the net effect of hyperglycemia (high blood sugar).

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Insulin is the main messenger that controls the body's storage and utilization of fuels. Therefore, the lack of insulin will lead to a breakdown of stored fat into free fatty acids which can lead to a severe disorder known as diabetic ketoacidosis. Insulin deficiency leads also to protein breakdown to glucose which may be a major factor in delayed wound healing.

There are two different types of diabetes. Type I (insulin dependent) represents 20% of the diabetics who need insulin to sustain life. The remaining 80% of diabetics have Type II (non-insulin dependent) diabetes which means that in most cases control of the disease can be obtained by implementing nutritional criteria, such as ideal weight maintenance, avoidance of concentrated sugars, regularity of meal times and quantity of food, and development of an individualized meal plan as well as an exercise program. It should be recognized that the success of any therapeutic regimen is directly related to the level of understanding achieved by the patient.3

At this time, Medicare does not specifically mention patient education as a covered item. In a very general way, Medicare in some states (Maine, Colorado, Michigan, New York) has determined that "reasonable and necessary" patient education programs may be covered as a physician's service or as aa paramedical service "incident to" a physician's service.4 Reimbursement is difficult and time consuming, and sometimes means these services are unavailable to the people who really need them. Also, it is not possible to get reimbursement for nutrition counseling sessions and follow-up sessions that diabetic patients need to evaluate their knowledge and expertise in, for example, following their meal plan and thus being successful at weight loss and maintenance. The consequence of this success is a decrease in blood glucose to near normal or normal levels along with a decrease in money spent on hospitalizations.

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The registered dietitian is the professional who has the expertise in nutrition to: (1) assess the patients' lifestyle, (2) develop the individualized meal plan, (3) implement habit changes which lead to decrease in weight, (4) implement increases in expended energy, and subsequently (5) positively impact blood glucose values. In my recent experience I have worked in a 5 day (25 hour) outpatient diabetic education program where 90% of the patients were Type II diabetics. Of those 200 patients, 190 had a decrease in blood glucose levels within the instruction week when instructed on principles of diabetes management including individualized meal plans. In many cases medication had to be decreased or stopped because the patient's blood glucose was too low.

A study assessing hospital admissions on 902 registered insulin treated diabetics showed that approximately 1/2 had participated in a diabetes education program and only nine of these patients were admitted. Seventy (70) insulin treated patients who had never had diabetes education were admitted.[5] Only 11.7% of the admitted patients had received diabetes education.

There is currently no cure for diabetes but it is possible to control the disease and minimize some of the chronic complications. Diabetes is the leading cause of new blindness in this country. It also causes problems with the kidney which often leads to kidney failure. Diabetics have an earlier incidence of cardiovascular disease. Diabetes is also one of the leading causes of amputation because of the decreased blood flow to the area which causes decreased wound healing. There is increasing evidence that good control can prevent or delay some of the complications of the disease which will in turn increase the quality of life, improve the course of the disease, and decrease the hospital costs of treating these patients.[6]

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Medicare beneficiaries are at a greater risk for Diabetes Mellitus because of their age and therefore their tendency for weight gain and inactivity. Diabetes education should be available to all of these patients because it is an integral component to treatment. Patients who have been properly educated can become active partners with the medical team in maintaining their health. This can lead to a reduction in diabetes morbidity, mortality, and related costs.

This opinion is supported by the California Dietetic Association's position on the reimbursement for Medicare beneficiaries.

Sincerely,

Leslie Eckerling R.D., M.S.

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Carol Loggins, R.D.,M.S.
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June 14, 1985

The Honorable Bob Packwood
Chair, Committee on Finance
Room SD-219
Dirksen Senate Office Building
Washington, D.C. 20510

Dear Senator Packwood:

The Statewide Health Education Advisory Committee (SHEAC) of Virginia applauds your interest in the health promotion and disease prevention needs of Medicare beneficiaries. To support your efforts, we wish to submit this statement for the record of the June 14, 1985 hearing of the Subcommittee on Health, to be conducted by the Honorable David Durenberger.

In 1972 the Virginia General Assembly mandated that health education efforts be "...directed toward prevention of illnesses...". As a result, the SHEAC was established to advise the Bureau of Health Education of the State Health Department. Since its formation, the SHEAC has strived to identify the needs of and promote health education programs for Virginia residents.

The health problems of older adults in Virginia are not unlike those experienced by other older Americans. Almost 70% of those persons over sixty years of age have at least one chronic condition such as arthritis or high blood pressure. Many are overweight, continue to smoke, fail to get regular, moderate exercise or otherwise put themselves at increased risk of developing major disabling illness. These data demonstrate the need for health promotion efforts aimed at older adults in order to reduce health risks and support healthy lifestyles in old age.

We would like to bring a program, located in Fairfax County, Virginia, to your attention. We believe the Health Education and Physical Fitness Project for Older Adults (HEP) at the Center for Health Promotion of George Mason University, represents an exemplary prototype of health promotion for the well elderly. Since only one in three older adults exercises on a regular basis, the HEP Project efforts focus on physical fitness as a health risk reduction tool.

During its first two years of operation, the HEP Project has accomplished the following:

1) Two times a week, for two hours each session, HEP participants engage in aerobic exercise, stretching, walking, tennis, and discussion of health topics. Significantly, of those older adults who leave the program, 49% continue to be regular exercisers six months later. In addition, this program has successfully become self-supporting through the institution of participant fees.

2) Older Adult Fitness Workshops have been conducted. Developed for health, physical education, gerontology and recreation professionals, the focus of these training sessions was on developing skills necessary for the implementation of safe and effective exercise progams for older adults.

3) A Peer Exercise Instructor Training Program was developed and implemented. By training older adults as peer exercise leaders the number of available programs, qualified leaders, and role models for older adult fitness in the county has increased. One hundred and eighty older adults are now exercising in one of new peer-led programs.

Older adults, as with persons of all other ages, can do a great deal to achieve and maintain their own good health. Studies indicate that appropriate regular physical exercise can aid in the prevention and/or management of most of the health problems experienced by older adults. Presently, osteoporosis results in two million deaths and many more disabilities each year. Exercise combined with adequate intake of calcium can prevent many of these deaths and disabling injuries. In addition, regular physical activity has been shown to improve the cardiovascular health of the older adult. Benefits such as lowered cholesterol levels, reduced blood pressure, reduced body fat, and the increased ability of the heart and blood to function efficiently have been documented. We believe health promotion services can reap cost benefits as well.

Many older adults are interested in becoming or remaining physically active. However, a variety of barriers keep them from doing so. Some of these barriers are: lack of accessible and appropriate programs; a shortage of skilled leaders; transportation and financial constraints; no one to exercise with and lack of support for exercise from health care professions. A reimbursement mechanism via Medicare would facilitate the development of appropriate health promotion services for older adults, reducing or eliminating these barriers.

Effective programs, such as the HEP Project, clearly demonstrate the potential for health promotion and disease prevention services for older adults. We strongly urge you, as Chair of the Committee on Finance, to pursue the provision of these services for Medicare beneficiaries nationwide.

Sincerely,

Marcia Nenno

Marcia Nenno
Chair, SHEAC

Elizabeth H. Howze

Elizabeth H. Howze, Sc.D.
Director, Center for Health Promotion

Texas Department of Health

Robert Bernstein, M.D., F.A.C.P.
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Hermas L. Miller
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Management and Administration

June 20, 1985

Anne Cantrel
Administrative Director
Committee on Finance
Room SD-219
Dirksen Senate Office Building
Washington, D.C. 20510

Dear Ms. Cantrel:

The Texas Department of Health would like to provide written testimony concerning health promotion and disease prevention strategies for Medicare beneficiaries to the Subcommitee on Health. Attached are five copies of a written statement for submission and inclusion in the printed record of the Subcommittee on Health hearing, June 14, 1985.

Sincerely,

Clift Price, MD

Clift Price, M.D., F.A.A.P.
Association Commissioner
Personal Health Services

Attachments

PCP/CL/sep

Subcommittee on Health Hearing
Subject: Health Promotion and Disease Prevention
Strategies for Medicare Beneficiaries
Date: June 14, 1985

Older adults are the fastest growing segment of the United States population, and with this trend comes health problems associated with increasing age. Older adults have a higher incidence of chronic disease, one of the most common being diabetes mellitus.

Patient education is medically necessary for persons with diabetes. It is an integral component of care, since education is necessary for the diabetic to manage the treatment regime on a daily basis. Studies have shown that inadequate patient knowledge results in multiple hospital admissions, an increased incidence of both acute and chronic complications and an increase in the economic and social burden of the disease. Studies have also indicated that the extended length-of-stay of hospitalizations are frequently for teaching purposes only.

Individuals with diabetes require considerable education if they are to assume knowledgeable responsibility for self-management. However, the knowledge, skills, attitudes, and motivation for self-care should be offered on an outpatient basis. Outpatient programs are more accessible to persons with diabetes, much less costly, and can be more tailored to meet individual needs.

It appears that Medicare policies on reimbursement for diabetes outpatient education vary from state to state. Since there are no specific regulations addressing this service, we would like to recommend that it be an identified benefit under the Medicare program. We believe there is sufficient evidence that significant savings in tax dollars would result.